Jul. 26. 2013 3:37PM DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764-RINP.__3 07/11/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED R 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (F 000) **INITIAL COMMENTS** {F 000} A revisit survey was completed on July 9, 2013 following acceptance of an Allegation of Compliance to remove the Immediate Jeopardy at F-323, F-490, F-501 and F-520, all with a Scope and Severity level "K", The revisit revealed the corrective actions implemented June 29, 2013 removed the immediate Jeopardy, but non-compliance continues at a "E" level scope and severity for F-323, F-490, F-501 and F-520. The facility is required to submit a Plan of Correction for the Immediate Jeopardy citations lowered in scope and severity and for all of the lower level non jeopardy citations. 483.10(c)(2)-(5) FACILITY MANAGEMENT OF {F 159} 1. Resident # 34 expired on June 6, 2013. The (F 158) SS=D PERSONAL FUNDS account was closed to the estate on June 19, 2013. 2. An audit by the Business Office Manager of the Upon written authorization of a resident, the 07/15/13 trust fund accounts on July 15, 2013 revealed no facility must hold, safeguard, marrage, and other trust fund accounts exceeding the limit account for the personal funds of the resident allowed by the department of human services. deposited with the facility, as specified in 3. A form letter (Attachment 1) will be routinely paragraphs (c)(3)-(8) of this section. sent by the Patient Trust Representative to the responsible party when the trust fund account is The facility must deposit any resident's personal approaching the limit allowed by the Department funds in excess of \$50 in an interest bearing of Human Services. The staff will work with and assist the family in spending down the monics. account (or accounts) that is separate from any of

LABORAPORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVES SIGNATURE

the facility's operating accounts, and that credits all interest earned on resident's funds to that

account. (In pooled accounts, there must be a

separate accounting for each resident's share.)

The facility must maintain a resident's personal

funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or

> TITLE isteath

4. The Business Office Manager will conduct a

monthly audit of resident trust fund accounts to ensure all accounts are within the balance limit

allowed by the Department of Human Services.

The Business Office Manager will report to the August QAPI Committee meeting any July

outcomes of concern and monthly thereafter.

Attachment 1: Form Letter - Notification of DHS

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nutsing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deliciencies are clied, an approved plan of correction is requisite to continued

petty cash fund.

Limit.

()09) DATE

Jul. 26. 2013 3:37PM

No. 6764 RIN P. 437/11/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB_NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING_ COMPLETED R 445141 B. WING 07/09/2013 NAMÉ OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 159} Continued From page 1 {F 159} The facility must establish and maintain a system that essures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act, and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources. reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on review of facility trust account ledger, patient trust accounts guidelines, and interview. the facility failed to notify residents and/or responsible parties of balances within two

reviewed.

hundred dollars of the Social Security income (SSI) resource limit for one resident (#34) of one hundred and thirty-one resident accounts:

PRINTED: 07/11/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIF	PLE CONSTRUCTION		<u>7. US38-U391</u> TE SURVEY
	F	IDENTIFICATION NUMBERS	A. BUILL	DING	ā	CO	MPLETED
	 ,	445141	B. WING	:		07	R
NAME OF	PROVIDER OR SUPPLIER			Sī	REET ADDRESS, CITY, STATE, ZIP CODE	t: Ur	<u>//09/2013</u>
BRADL	EY HEALTH CARE & R	EHAB] :	2910 PEERLESS RD		
(X4) ID	SUMMARYETA	TEMENT OF DEFICIENCIES			CLEVELAND, TN 37312		
PREFIX TAG	-1 (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	BE	COMPLETION DATE
(F 159)	The findings include Review of the facility	ed: y trust account ledger dated esident #34 revealed the	{F 1	59}			
	February, 2013: \$16 March, 2013: \$17,8 April, 2013: \$18,465 May, 2013: \$19,676 June, 2013: \$21,686	5,127.75 07.68 5.05 5.74 5:99					
	Review of facility "Pa	facility documentation at expired on June 6, 2013.					
	Of Attomey)/Contact	ed) revealed "POA (Power person will be notifiedbal is close to the limit allowed of		,			
į	Account Manager's account exceeded the 2013, after the resident	esident Account Manager on 30 a.m., in the Resident office, revealed the resident's ne \$2000.00 limit in January ent received a lump sum					
	notified the resident representatives of the amount in the residences than the SSI residences.	e SSI resource limit when the nt's account reached \$200 cource limit for one person.	•				
(F 160) SS=D	483.18(c)(6) CONVE FUNDS UPON DEAT	YANCE OF PERSONAL TH	{F 16	0}			
ļ	Upon the death of a proposited with the far	resident with a personal fund Gility, the facility must convey					

Jul. 26. 2013 3:38PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764PRIN 07/11/2013
FORM APPROVED
OMB NO. 6938-0301

	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CV21 North		OMB N	<u>10. 0938-03</u>	39
	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	Y BUILD	TIPLE CONSTRUCTION	1 (EX)	DATE SURVEY COMPLETED	
İ	titie or		445141	B. WING			R	
	1	PROVIDER OR SUPPLIER EY HEALTH CARE & R	EHAB		STREET ADDRESS, CITY, STATE, ZIP COD 2910 PEERLESS RD	<u> (</u>	07/09/2013	
ľ	(X4) ID	SI IMMANUV STA	EMENT OF DEFICIENCIES		CLEVELAND, TN 37312			
	PREFIX TAG	I LENGT DEFICIENCY	MUST BE PRECEDED BY FULL G IDENTIFYING INFORMATION)	PREFID TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE	역에서 마셨어요?	COMPLETIC DATE	N
	{F 160}	accounting of those probate jurisdiction a estate.	funds, to the individual or administering the resident's	{F 16	cstates. 2. On July 15, 2013 the trust fund at residents had been discharged/death by the Business Office Manager for	executor of the ecounts where hwere reviewed	d	-
		Based on review of and interview, the far convey personal functions (#76 and # thirty-one resident action The findings included Resident #76 expired of a facility trust fund revealed a balance of trust account.	f: I on May 10, 2013. Review ledger on June 17, 2013, f \$2,159.14 in the resident's		and none were found with a date of a days. 3. The patient trust fund representate a daily census log and will log (Attactive the date of discharge/death to trust fund account is closed within 30 discharge/death. 4. The Business Office Director will a the discharge/death log (Attachment the account is closed within 30 days of death. A monthly accounting will be QAPI Committee.	tive will receive chrient 2) and assure the 0 days of monthly audit 3) to assure	P	
		revealed a balance of trust account.	on May 12, 2013. Review ledger on June 17, 2013, \$2,099.01 In the resident's		Discharge/Death Log Discharge/Death Audit Form	•		
+	(F 166) SS=D F	Office Manager's office the trust accounts had residents' estate. 483.10(f)(2) RIGHT T(RESOLVE GRIEVANCE) A resident has the right actility to resolve griev.	iness Office Manager on p.m., in the Business e. confirmed the balance in not been returned to the DEROMPT EFFORTS TO DES to prompt efforts by the ences the resident may with respect to the behavior	{F 166}	1. On 6/12/13 a Share Card was complete, and the state of the amount of the state o	ney. An Services	07/18/13	
2	M CMS-2507	702:00\ Deexders \$10-1			<u>. </u>			1

No. 6764-RIN. 7. 07/11/2013 FORM APPROVED

STATEMEN AND PLAN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIP	LE CONSTRUCTION		<u>2, 0938-0391</u> TE SURVEY
	•	DENTIFICATION NUMBER:	A BUIL	DING			MPLETED
		445141	B. WING	3			R
NAME OF	PROVIDER OR SUPPLIER			sm	REET ADDRESS, CITY, STATE, ZIP CODE	1 01	7/09/2013
BRADLE	EY HEALTH CARE & R	ЕНАВ	ı	2	910 PEERLESS RD CLEVELAND, TN 37312		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	 .	
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	re Rate	COMPLETION DATE
	by: Based on medical the facility falled to go for two residents (#2 residents reviewed. The findings include Resident # 21 was a February 21, 2011, was a February 21, 2012, revealed "ha searchedput on all money"	is not met as evidenced record review and interview promptly resolve greivances 21 and #210) of fifty-six id: admitted to the facility on with diagnoses including allure, Pleural Effusion, ision, Anemia, and iservice (SS) Progress Note 12, revealed "can voice all press Note dated August 31, id money missingroom ortlook & (and) report any	(F 1		On 6/9/13 Resident # 210's husband verbali Therapy personnel that his wife's geri-chair too heavy for him to push. After discussion Therapy Director, Resident # 210 was fitted Broda chair. Resident's husband expressed this chair was much easier to propel. On 7/the Administrator, DON, and Social Services Director reviewed and revised the Grievance process policies and forms. (#4) The revised process, policy and forms were approved by Medical Director on 7/19/13. Nurses, Mana and Social Services staff were provided with service education (#5) by the Administrator the grievance process, policy and forms on 7/18/13. Pamilies and residents are made and the grievance process upon admission and for are kept at the nurses' desks. 2. On July 18, 2013 the Social Services Directories wed the resident council minutes and for no unresolved grievances. 3. A new log and grievance form (#4) has be developed. The log will be maintained in the Social Services office. The Administrator will monitor the grievances, concerns and compliances investigated to ensure all resident grievances logged and investigated according to policy. Monitoring will begin on 7/15/13 on a weekly with review of 100% of grievances. Results of monitoring will be reported to the QAPI	was with with a that 12/13 \$ the gers in- on zere of orms tor und en l aints are	
1	Review of a (SS) Pro September 3, 2012, I turned in, nsg (nursin staff about this"	gress Note dated revealed " no money ig) awaretalked c (with)	•		Committee by the Social Services Director. T QAPI Committee will evaluate the frequency monitoring based on compliance with the pol after 6 months.	ا عم	
	2012, revealed "mo Review of a SS Progr	ress Note dated June 12, / (Social Worker) was made		i d	4. The Social Services Director will report monitoring of the July outcomes of concerns, complaints, and grievances at the 8/14/13 QA Committee meeting and monthly thereafter untofitoring and reporting are changed based acidity compliance. The Administrator will result to the governing body monthly.	ntil	
				- [•	1	Į.

Jul. 26. 2013 3:38PM DEFARTMENT OF HEALTHAND HUMAN SERVICES No. 67642RINP 8 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEPICENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (K2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PREFIX PROVIDER'S PLAN OF CORRECTION O(5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) **₹** 1663 Continued From page 5 Attachments: {F 166} Interview with the SW on June 12, 2013, at 8:30 #4 Revised Resident Grievance Policy and a.m., at the Wing 1 Nurses Station, confirmed the Procedure, Log and Form facility had failed to resolve the greivance of #5 In-Service Log of Attendance missing money until brought to the attention of the facility by the surveyor on June 12, 2013, (10 months later). Resident #210 was admitted to the facility on November 21, 2012, with diagnoses including Pneumonia, Neurological Disorder Multiple Infarcts, Demenita, Tracheostomy, Gastrostomy, Encephalopathy, and late effects Viral Encephalopathy, Interview with the resident's spouse on June 10, 2013, at 4:20 p.m., in the Wing 2 dining area, revealed the spouse was unable to push the resident's wheelchair due to the heaviness and unyieldingness of it. Stated "... I've asked for a lighter one and they told me i couldn't get it..." Further interview revealed the spouse would like to push the resident around the facility but is unable to push the wheelchair "...it is too hard to push...." Contined interview revealed appuse had discussed the request with the Activity Aide and the Therapy Director. 1.50

FORM CMS-2567(02-99) Previous Versions Obsolete

push "a few months ago,"

Interview with the Activities Director and the Activity Aide on June 11, 2013, at 8:45 a.m., in the Activities Office, confirmed the resident's spouse had requested an easier wheelchair to

interview with the Therapy Director on June 12, 2013, at 9:20 a.m., in the conference room, revealed the spouse had spoken to him about a wheelchair the spouse could push to take the resident to activities. The Therapy Director stated

Event ID: 32HM12

Facility ID: TN0601

If continuation sheet Page 6 of 39

Jul. 26. 2013 3:39PM DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764-RINP 9 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX (XS) COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 166) Continued From page 6 (F 166) had attempted a different chair but there was a mechanical problem so could not use that chair. Further interview revealed had "thought about" a "Broda" Chair but "need to get permission for that.* Observation on June 18, 2013, at 5:00 p.m., at the Wing 2 nursing station, revealed the resident in a reclining type wheelchair with the spouse attempting to push it. The spouse was having difficulty and a staff member assisted. Interview with the Therapy Director on June 12, 2013, at 9:20 a.m., in the conference room, confirmed the facility failed to resolve the grievance. 483.13(a) RIGHT TO BE FREE FROM {F 221} PHYSICAL RESTRAINTS (F 221) RESIDENT # 71 SS≃D⊤ 1. The DON, Administrator, Medical 07/15/13 Director, and Clinical Manager reviewed The resident has the right to be free from any physical restraints imposed for purposes of Physician Orders on resident #71 on discipline or convenience, and not required to 6/26/13. Resident received clarification treat the resident's medical symptoms. order for softbelt while up in w/c due to unsteady gait and decreased cognition on 6/26/13. The order was faxed to Pharmacy, This REQUIREMENT is not met as evidenced placed on careplan and documented on by: current MAR. 11.5 Based on medical record review, observation, 2. On 7/11/13, the DON, ADON, Staff and interview, the facility failed to obtain an order Development Nurse, and Clinical Managers for a restraint for one resident (#71) of 5 residents assessed all residents with restraints to reviewed. ensure orders are current on MARs and

The finding included:

Depression, and Anxiety.

Resident #71 was admitted to the facility on

January 17, 2011, with diagnoses including

Ostegarthritts, Dementia, Alzheimer's Disease,

physician orders. The MDS Coordinator

Beginning 7/11/13, a restraint log (P) was

completed for all residents who had

restraints by DON and/or ADON and

reviewed the careplan and MDS assessment for compliance and no update needed.

Jul. 26. 2013 3:39PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764-RIN P. 107/11/2013
FORM APPROVED
OMB NO. 0222 0224

AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(V9) 18	·	N = 001	<u>ЭМВ N</u>	IO. 0938-039
~ 4D 1 DA14 D	+ CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	LE CONSTRUCTION	(X3) D	DATE SURVEY COMPLETED
NAME OF S		445141	B. WING	3		1.	R
BRADLE	ROVIDER OR SUPPLIER Y HEALTH CARE & R			[2	REET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312	<u> </u>	<u>)7/09/2013</u>
(X4) ID PREFIX TAG	CEPUT DEFICIENTLY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(XS) COMPLETION DATE
Mail Bellin Mail Bellin Mail Bellin B	Deal Set (MDS) date the resident had several transfers, two or more transfers, two or review decical record review decical re	sw of a quarterly Minimum and April 30, 2013, revealed ere cognitive impairment, ssistance of one for re falls without injury, and no w of a Care Plan dated ealed "at risk for fallsfall oft belt applied" w of a Pre-Restraining larch 23, 2013, revealed eandations: O.T of eval (evaluation) W/C ng" w of an informed Consent of a revealed the family had for restraint use. of a ADL (activity of daily living) p. 2013, revealed "restraint ul" of a Physical Restraint nt dated May 31, 2013, tinue) with seat belt"	{F 2:			ting ted tr vas ent ding tors tors tors tors tors tors tors tore ers iny ell ir or	

<u>Jul. 2</u>6. 2013 3:39PM DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764 PRIN 1 1 17/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X4) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING_ COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (XS) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {F 221} Continued From page 8 (F 221) the Wing One Dining Room, revealed the resident in a wheelchair with a soft belt restraint in place. Interview on June 11, 2013, at 3:55 a.m., in the Wing One Nurse's Station, with the Wing One Unit Manager, confirmed the facility falled to obtain a physician's order for the soft belt restraint. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT {F 225} 1. Resident # 134 sustained fx femur on 85=D ALLEGATIONS/INDIVIDUALS 11/13/12. DON sent Unusual Event Report 07/15/13 to the State of Tennessee on 7/10/13 The facility must not employ individuals who have describing the event and the findings of been found guilty of abusing, neglecting, or investigation. No other action was required. mistreating residents by a court of law, or have 2. Quality Assurance (QA) nurse reviewed had a finding entered into the State nurse aide incidents of unknown origin for the past 60 registry concerning abuse, neglect, mistreatment days which may be reportable to state and of residents or misappropriation of their property, none were noted. and report any knowledge it has of actions by a 3. QA Nurse will investigate each incident court of law against an employee, which would for unknown origin per policy (R). Nurses indicate unfitness for service as a nurse aide or and Clinical Managers will investigate other facility staff to the State nurse aide registry immediately upon occurrence or discovery or licensing authorities, to determine if the incident is an unknown origin. An Unusual Event Report will be The facility must ensure that all alleged violations completed and sent to the State of involving inlatreatment, neglect, or abuse, Tennessee when incident occurs which including injuries of unknown source and

misappropriation of resident property are reported

immediately to the administrator of the facility and

through established procedures (including to the

The facility must have evidence that all alleged

violations are thoroughly investigated, and must

to other officials in accordance with State law

State survey and certification agency).

prevent further potential abuse while the

investigation is in progress.

meets the regulation criteria. Incidents will

be reviewed and discussed upon occurrence

at the morning meting with DON, ADON,

Administrator. At the monthly review of

incidents with the Medical Director it will

be discussed as an unknown incident and so

Clinical Mangers, Rehab and

noted on the incident report.

Jul. 26. 2013 3:39PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER'S UPPLIERCED
DENTIFICATION AND MARKETED.

No. 6764 RIN! 127/11/2013 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OMB	NO. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILL	LTIPI DING	LE CONSTRUCTION		DATE SURVEY COMPLETED
		445141	B. WING	·	<u></u>		R
BRADLI	PROVIDER OR SUPPLIER EY HEALTH CARE & R		•	2	REET ADDRESS, CITY, STATE, ZIP CODE 910 PEERLESS RD CLEVELAND, TN 37312		07/09/2013
(X4) ID PREFIX TAG	I YEARD DEPUBLISHMEN	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
(F 226)	The results of all invito the administrator representative and twith State law (includent) incident, and if the a	estigations must be reported	(F 2:	25}	4. Beginning July 10, 2013, the DC report any incident reported to the Tennessee due to unknown origin QAPI committee. The Administrateport to the governing body these monitoring outcomes on a quarter or more often as necessary.	State of to the tor will	
	Based on review of a of facility policy, and submit a written repo origin to the State De	T is not met as evidenced facility documentation, review interview, the facility falled to set of an injury of unknown epartment of Health for one thleen residents reviewed for					
	Review of facility doc November 13, 2012, a Resident #134's right transferred to the Em have a distal femur for facility documentation revealed the University	umentation revealed on staff noted edema to knee. The resident was ergency Room and found to acture. Confinued review of dated November 16, 2012, Event Report had been staff on the send the se	-				
, , , , , , , , , , , , , , , , , , ,	-www. IN vale. Terepi	y, Reporting of Incidents to ed "The facility will report within 7 business days"					
() J	nterview with the Dire june 13, 2013, at 8:05	ctor of Nursing (DON) on a.m., in the DON Office,					

Jul. 26. 2013 3:40PM
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764RINP. 137/11/2013 FORMAPPROVED

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/Y2\ MIII	TICH	LE CONSTRUCTION		<u>. 0938-0391</u>
AND PLAN	OF CORPECTION	IDENTIFICATION NUMBER:	A. BUILO	NO			TE SURVEY VPLETED
NAME OF	PROVIDER OR SUPPLIER	445141	B. WING			i	R / 09/20 13
	Y HEALTH CARE & R	ЕНАВ		2	REET ADDRESS, CITY, STATE, ZIP CODE 910 PEERLESS RD LEVELAND, TN 37312	<u> </u>	100100
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	confirmed the facility report of an injury of fractured femur to the 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an elembances each resident and in an elembances each resident full recognition of his REQUIREMEN by: Based on observational falled to maintein the residents (#9, #209, observed dining, in a Sunshine Dining Ropermission before playenty-four residents (wing 1 dining room) observed. The findings included the Sunshine Dining seated with five resident #1: their lunch trays and observation revealed resident #1: their lunch trays and observation revealed were not eating and adming room. Continued observation fractions #111: and findings #111: and finding room.	y failed to submit a written of unknown origin resulting in a funknown or Tennessee. AND RESPECT OF In the seriodents in a province of the maintains or dent's dignity and respect in a funknown or funknown or funknown or funknown or five residenced on and interview, the facility and dignity and respect for three and #58) of five residents one of six dining rooms (the funknown) and failed to ask facing clothing protectors on a failed to ask facing clothing protectors on a funknown of six dining rooms of six	{F 24	11)	Resident # 9, #209, #58 1. The Dietary Department was notified 6/10/13 of residents # 9, #209, and #58 attending the Sunshine Room during me Trays will be placed on the cart to be delivered to the Sunshine Room effective 6/10/13. In-servicing regarding dignity issues, deliof trays, and placing clothing protectors began on 7/12/13 for nursing and staff assisting with meal delivery by DON/AD Staff Development Nurse and is ongoing. 2. All residents were assessed for their preference pertaining to use of a clothing protector by the Clinical Manager on 7/12/13. A list of residents who prefer to have clothing protectors will be available staff in the dining areas effective 7/12/13 addition to the list each resident will be a prior to having clothing protector placed Dietary Department will continue to be notified verbally or in writing when a resident's location for meals change by thursing staff or clinical manager immediprior to delivery of trays.	ivery (S) ON/ e for In isked	07/15/13
	revealed resident #9	received a lunch tray and			_	- 1	

Jul. 26. 2013 3:40PM DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764 RIN . 147/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED R 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (XS) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {F 241} Continued From page 11 3. DON/ADON or Clinical Managers will {F 241} began eating. make a Dining Observation using the Dining Observation tool (T) beginning 7/15/13 on a Continued observation at 12:22 p.m. (10 minutes weekly basis for 4 weeks then monthly. after residents #111 and #177 began eating), Results of the dining observations will be revealed residents #209 and #68 received their reported to the QAPI committee at each lunch trays and staff members sat down beside meeting. them to assist with feeding. Further observation 4. Beginning July 2013, the Clinical revealed resident #177 had finished eating when residents #209 and #58 received their trays. Managers will report weekly to the DON concerning the monitoring of dining Interview with Restorative Aide #1 on June 10. observations at the morning meetings. The 2013, at 12:31 p.m., in the Sunshine Dining DON will report the dining observation Room, revealed residents #9, #209, and #58 monitoring outcomes to the QAPI lunch trays were delivered to the wing where the committee beginning with the August QAPI residents' rooms were located and someone had Meeting. The Administrator will report to to go retrieve the trays from those wings and the governing body concerning these bring to the Sunshine Dining Room. monitoring outcomes on a quarterly basis or more often as necessary. Interview with Unit Manager #3 on June 10, 2013, at 12:40 p.m., in the Sunshine Dining Room, revealed the Sunshine Room was for residents Who need one-on-one supervision and was the dining room for residents with behaviors. Further interview confirmed the three residents did not get their trays with the other two residents and "! don't know why."

Observation of the Wing I dining room, on June 10, 2013, from 11:45 a.m., until 12:10 p.m., revealed the Care Assistant Technician (CAT) #1 placed clothing protectors on twenty-four residents without asking permission from each resident before placing the clothing protectors.

Interview with CAT #1 on June 10, 2013, at 12:33 p.m., at the Wing 1 Nurses' station, confirmed none of the twenty-four residents had been asked permission before placing the clothing protectors.

CENT	FIND LOW MEDICAKE	AND HUMAN SERVICES & MEDICAID SERVICES		No. 6764	P. PIN: EI FORI	15 US U7/11/20 MAPPROVE
AND PLA	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	OFFLE CONSTRUCTION NG	(X3) DA	D. 0938-039 TE SURVEY MPLETED
NAME OF		445141	B. WING		l	R
BRADI	PROVIDER OR SUPPLIER EY HEALTH CARE & R	<u></u> .		STREET ADDRESS, GITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 37312	07	/09/2013
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33=L	The facility must cor a comprehensive, as reproducible assess functional capacity. A facility must make assessment of a resident assessment by the State. The as least the following: Identification and der Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior persychosocial well-bein Physical functioning a Continence; Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sum	educt initially and periodically exurate, standardized ment of each resident's a comprehensive ident's needs, using the instrument (RAI) specified sessment must include at mographic information; attems; ag; and structural problems; ad health conditions; status;	(F 272	Resident # 71 1. The DON, Administrator, and MDS Coordinator reviewed MDS assessment 04/30/13 for resident # 71 on 7/9/13. M modification and submission (U) done of 7/9/13 reflecting use of trunk restraint w up in w/c. Modification was made to the MDS Assessment with an ARD Date of 4/30/13 for Resident # 71. The correction was made to Section P, Item A, identifyin trunk restraint for the resident. The modification was transmitted on 7/9/13. 2. The DON, ADON, Clinical Managers and MDS Coordinator reviewed all reside with restraints to ensure MDS assessment were correctly coded and up to date on 7/11/2013. There were no corrections identified in the review. 3. Beginning 7/15/13, the MDS Coordinators will review restraints marke on MDS assessments and careplans for accuracy in the weekly careplan conference with the Clinical Managers. Beginning August, the DON or ADON will review for careplans per month which include various.	dated DS on when he ig a ents ts	07/15/13
}	areas triggered by the Data Set (MDS); and	nent performed on the care completion of the Minimum		is met as approved by the QAPI committee DON will report results of monitoring at		
1.	Draumantail			O A DY marking		

Documentation of participation in assessment.

QAPI meeting.
4. Beginning Aug 2013, the DON will report

the MDS monitoring outcomes to the quarterly QAPI committee 8/14/13. The Administrator will report to the governing DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2013 FORM APPROVED

THE TOTAL	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Y BUILDING _	CONSTRUCTION	(X3) DA). 0938-0: TE SURVEY MPLETED
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(F 272)	Continued From pag	ge 13	{F 272}			
	Based on medical name interview, the far accurate comprehen	T is not met as evidenced ecord review, observation, cility failed to complete an asive assessment for one six residents reviewed.		·		
1	The findings included				ļ	
1	Section 11. Strat. 199	mitted to the facility on th diagnoses including ntia, Alzheimer's Disease, lety.				
	Medical record reviev January 3, 2012, reve 3/23/13no injurys	v of a Care Plan dated ealed "at risk for fallsfall oft belt applied"	i			
E	valuationRecomm	arch 23, 2013, revealed				
th re tr	16. resident had sever 30. resident had sever 30. resident had sever	of a quarterly Minimum April 30, 2013, revealed e cognitive impaiment, istance of one for falls without Injury, and no	-			
1	edical record review imination Assessmen vealed *Cont (conti	of a Physical Restraint at dated May 31, 2013, nue) with seat belt"				
CMS-2567(n	(2-99) Providus Versions Obso	lete Event ID:32HM12		•	1	

CENT	ENO FUR MEDICARE	AND HUMAN SERVICES			RIN 177/11/20
1 O I MI S MI C I	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. Blill	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		445141	B. WING		R
	PROVIDER OR SUPPLIER EY HEALTH CARE & R	EHAB		STREET ADDRESS, GITY, STATE, ZIP CODE 2910 PEERLESS RD	07/09/2013
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	Observation on June the Wing One Dining resident in a wheels used. Interview on June 11 Wing One Nurse's S Nursing, confirmed the assessment was not 483.20(d)(3), 483.10 PARTICIPATE PLAN. The resident has the Incompetent or other incapacitated under the participate in planning changes in care and A comprehensive car within 7 days after the comprehensive assess interdisciplinary team, physician, a registere for the resident, and of disciplines as determined, to the extent praiting representative.	e 10, 2013, at 10:43 a.m., in g Room, revealed the hair with a soft belt restraint . 2013, at 3:55 p.m., in the tation, with the Director of he comprehensive accurate. (k)(2) RIGHT TO INING CARE-REVISE CP right, unless adjudged wise found to be he laws of the State, to g care and treatment or treatment.	{F 28	Resident # 111, #141 1. On 7/9/13, the DON, Administrator, ADON, Clinical Managers and MDS Coording reviewed and revised the careplan for resider #111 to remove "1:1 Supervision" and add "a sunshine room for direct supervision" and Resident # 141 careplan to reflect "re-educative call light when in need of assistance".	instors nt titends e to falls und a d mo were d by

This REQUIREMENT is not met as evidenced

Based on medical record review, review of facility

documentation, and interview, the facility failed to

MDS Coordinators and Clinical Managers will review the careplan at this time to ensure that

the fall interventions are in place. The ADON and MDS Coordinators will review occurrences

and ensure interventions are on the careplans

and assess resident for compliance.

Jul. 26. 2013 3:41PM No. 6764 P. 187/11/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED R 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2010 PEERLESS RD CLEVELAND, TN 37312 (Xa) (D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (NS) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) {F 280} Continued From page 15 Beginning August 2013 the DON or ADON (F 280) revise the care plan for two residents (#111 and will review four care plans per month which #141) of fifty-six residents reviewed. include falls for six months or until substantial compliance is met as approved by The findings included: the QAPI committee. DON will report results of monitoring at the QAPI meeting. Resident #111 was admitted to the facility on August 24, 2010, with diagnoses including 4. Beginning Aug 2013, the DON will report Atriovent Block First Degree, Cardiac careplan monitoring outcomes at the Dysrhythmias, Cardiomegly, Congestive Heart scheduled 8/14/13 QAPI committee Failure, and Sinoatrial Node Dysfunction. meeting. The Administrator will report to the governing body concerning these Medical record review of the Care Plan for the Problem Category of Falls revealed an monitoring outcomes on a quarterly basis or intervention dated May 19, 2011, "... Restorative more often as necessary. Nursing for Ambulation R/T (related to) unsteady gait...risk factor: accidents..." The Care Plan had been updated for review ten times and had a new target date of September 10, 2013. Continued review of the Care Plan revealed on December 21, 2011, "...Fall: 12/21/11 no injury 1:1 (one on one) supervision..." No changes to the one on one intervention had been made since December 21, 2011. Review of facility documentation revealed on June 4, 2013, at 4:30 a.m., "...activity referral for early awakening prior to sunshine room attendance..." Medical record review of the care plan revealed no documentation of the intervention for the

sunshine room.

Interview with the Director of Nursing (DON) on June 17, 2013; at 2:05 p.m. in the DON office confirmed the care plan had not been revised to

Continued interview with the DON confirmed the

reflect the intervention of June 4, 2013.

Jul. 26. 2013 3:42PM DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764 RINP. 197/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING 445141 B. WING R NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ADTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (X5) COMPLETION DATE TAG (F 280) Continued From page 16 (F 280) resident intervention of 1:1 from December 21, 2011, was no longer in place and the care plan for 1:1 had not been revised. Resident #141 was admitted to the facility on August 19, 2008, with admitting diagnoses of Urinary Tract Infection, General Osteoarthritis, Renal & Ureteral Disorder, Spasm of Muscle, Generalized Pain, Bone/Skin Neoplasm, and Osteoporosis. Review of the facility's documentation of falls that occured on April 16, 2013, and May 18, 2013, revealed an intervention of "re-educate to use call tight when in need of assistance". Medical record review of the Care Plan for falls revealed the new intervention for fall prevention for the falls on April 16 ,2013, and May 18, 2013, had not been added to the Care Plan. Interview with the DON on June 13, 2013, at 9:45 a.m., in the conference room, confirmed the resident's Care Plan had not been revised to reflect the fall intervention ordered. {F 281} 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS {F 281}

FORM CMS-2567(02-99) Previous Versions Obsolete

by:

The services provided or arranged by the facility

must meet professional standards of quality.

This REQUIREMENT is not met as evidenced

Interview, the facility falled to ensure well-being,

dialysis provider, medical record review and

Based on review of the facility's contract with the

Event ID: 32HM12

place. Staff in-servicing regarding Facility ID: TN0801

Resident # 230

1. A clarification order for dialysis

communication form was constructed for use on 6/13/13. Dialysis clinic received communication from BHRC nurse and

returned documentation/communication

2. There are no other residents receiving

dialysis at the dialysis center at this time.

All new communication forms (V) are in

was obtained on 6/13/13. A dialysis

with resident appointment info.

If continuation sheet Page 17 of 39

07/08/13

Jul. 26. 2013 3:42PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 67649RINP. 2017/11/2013 FORM APPROVED

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l	NAME OF	PROVICER OR SUPPLIER	445141	B. WING	·_			R
l					ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 07/	/ 09/2013
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	{F 281}		ge 17	{F 26	R11	Care of a dialogic socident - ali - an i		
		for one resident (#2	30) of one resident receiving	יי די	013	care of a dialysis resident policy (V) beg 7/8/13 and is ongoing as needed per Cli	an o <u>n</u>	
		dialysis, of fifty-six re	esidents reviewed.			3. In-servicing regarding care of recider	.+	
		The findings include	ų;			and communication tools (V) will be on	anina l	
		•				to ensure policy and contract is followed		
		Resident #230 was a	admitted to the facility on			Clinical Managers will review communic tools and dialysis clinic notes after each	ation	
	i	Pheumonia End Sta	lagnoses including Sepsis, age Renal Disease, Diabetes		- 1	appointment. DON and/or ADON will	he	<u> </u>
		Mellitus I), Pressure	Ulcer, and Mental Disorder.			notified if any discrepancies arise.	~	
	ľ				ľ	4. Clinical Managers will review for	j	
		Medical record review	w revealed the resident		-	compliance and any reports/trends of co will addressed to the QAPI committee by	ncern	1
	j	dialysis provider and	illysis from the contracted revealed no facility to facility		ŀ	DON beginning with the scheduled 8/14	120	ł
	- [communication.	TO TO INCIDENTY IN TACKETY		- 1	WAP meeting. The Administrator will -		
	- 1	Rovins of the feature			- 1'	to the governing body on a quarterly basi	s or	
)	I COMMITTE I CAGGINGO 15.	contract with the dialysis sponsibilities of BHRC		- [more often as necessary.	- 1	
		Colouge Health Cara	& Robok) DUDA ALAR		褙		}	
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	ſ	THE CONTRACTOR STATE	dialyzedthis assessment to the facility's nurse		- 1		[
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	fi	nonitoring of a patient	t With chronic renal nich may be utilized in the			••	1]
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FORM CMS-2567(02-89) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0838-0391 (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) (F 281) Continued From page 18 (F 281) Interview with Unit Manager #1, on June 13, 2013, at 9:50 a.m., in the Wing 1 nursing station, confirmed there was no order for the dialysis. Continued interview with the Unit Manager confirmed no staff education regarding dialysis and shunt site care had been completed for the Nurses or the Certifled Nursing Assistants. Further interview revealed the facility received a faxed copy of the Outpatient Dialysis Flowsheet from the dialysis facility if they "call and ask for it." Further interview confirmed the only communication between the facility and the dialysis facility was a phone call "if needed". The information was not sent back to the facility immediately post dialysis and no regular communication was provided. Continued interview confirmed there was no facility to facility communication including documentation of assessment by the facility prior to sending the resident to dialysis and no documentation from the dialysis center communicating the care and condition of the resident during and returning from dialysis. Further interview with the Unit Manager confirmed the facility contract with the dialysis center had not been followed. {F 323} 483.25(h) FREE OF ACCIDENT SSEE HAZARDS/SUPERVISION/DEVICES 1. # 134 (F 323) Treatment plan and falls interventions 07/15/13 were reviewed by DON, ADON, and MDS The facility must ensure that the resident Coordinator on 6/20/13, noting environment remains as free of accident hazards clarifications to interventions on 6/19/13 as is possible; and each resident receives being fall mats next to bed (not PRN) and adequate supervision and assistance devices to on 6/24/13 clarification of assist up for prevent accidents. meals and offer assistance to Dining Room (resident refuses at times), resident fed by staff in room as needed. Fall Interventions for this resident are:

Event ID: 32HM12

Low hed in low position and wheels

If continuation sheet Page 18 of 39

Facility 10: TN0601

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/11/2013

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	This REQUIREMENT by: Based on medical real investigation do of manufacturer's resonance in manufacturer's resonance in manufacturer's resonance in manufacturer's residents (#134, #37 #193, #2, #18) # fift failed to a apply soft manufacturer's instruction of five soft belt restration in immediate Jettle provider's noncorrequirements of partifical to cause, serior or death to a resident reviewed for falls. The effective interventions devices were in place fallure to identify and interventions when cueffective was likely to for falls in Immediate. The facility provided a Allegation of Compilar revisit on July 9, 2013 actions impiemented Jeopardy on June 29, and actions impiemented Jeopardy on June 29, and actions impiemented Jeopardy on June 29, and actions impiemented Jeopardy on June 29, and actions impiemented Jeopardy on June 29, and actions impiemented Jeopardy on June 29, and actions impiemented in the facility on June 29, and actions impiemented in the facility on June 29, and actions impiemented in the facility on June 29, and actions impiemented in the facility of June 29, and actions impiemented in the facility of June 29, and actions impiemented in the facility of June 29, and actions impiemented in the facility of June 29, and actions impiemented in the facility of June 29, and actions impiemented in the facility of June 29, and actions impiemented in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 29, and actions in the facility of June 2	record review, review of facility cumentation, interview, review commendations, of facility restraint committee of review of the facility pelicy Guidelines, the facility falled on to prevent accidents for tendon to prevent according to actions for one resident (#13) actions for one resident (#13) actions for one resident (#13) actions for one resident (#13) actions for one resident (#13) actions for one resident (#13) actions (#134, #37, #58, expandy (a situation in which impliance with one or more icipation has caused, or is us injury, harm, impairment, to of eighteen residents expressed at risk for falls was provided at risk for falls was provided at risk for falls was provided and implement new ultrent interventions were not place any resident at risk Jeopardy. An acceptable Credible nee on June 29, 2013. A b, revealed the corrective removed the Immediate	{F 32		locked, fall mats beside bed, soft belt rin w/c, up for meals as tolerated, bed a Resident care plan was reviewed on 6/by MDS Coordinator and DON assess resident care plan and spoke with resident care plan and spoke with resident care plan and spoke with reside/20/13. Resident was in w/c with no onoted. Medical Director reviewed treat plan, including falls interventions and reaffirmed plan of care on 6/25/13. Discare staff was in-serviced on intervention changes on 6/24/13 by Clinical Manager then in-service information placed in the service communication book and interventions added to nursing and CN care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review service sheets and signatures daily x 2 wor longer as appropriate to monitor state awareness. This will be reviewed by DC ADON, Staff Development Nurse for compliance – random reviews, two timeweek for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted and placed in communication for Clinical Manager/Weekend Supervisor review. ADON did a room check on equipment environment on 6/19/13 ensuring proper devices were in place and operational (to bed, floor mat, bed alarm). 337 Treatment plan and falls interventions we reviewed by DON, ADON, and MDS Coordinator on 6/20/13, with changes to blan being anti-tippers to w/c on 6/24/13 fall interventions for this resident are:	larm. 19/13 ed lent on distress timent rect on er and he in- lA l w in- weeks ef ON/ es a d d cted cal and er ow	
				l a	all interventions for this resident are: b gainst wall, floor mat, anti-tippers on w off belt in w/c, and chair alarm in	أامم	
M CMS-2567	(02-99) Plavious Versions Ob	solete Event ID: 82HJ412	r.	- 	DETUCK		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 445141 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD BRADLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 (X4) TD SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) room. DON assessed resident and care plan {F 323} Continued From page 20 (F 323) on 6/24/13. Changes/updates made to care Validation of the Credible Allegation of plan, resident in w/c with soft belt applied. Complaince was accomplished through medical Medical Director reviewed treatment plan, record review, review of facility communication including falls interventions and reaffirmed books, observation and interview with front line plan of care on 6/25/13. Direct care staff was staff and administrative staff. The facility provided in-serviced by Clinical Manager on 6/24/13 evidence of new policies and procedures related and then in-service information placed in the to accidents and supervision, chair and bed in-service communication book and alarms, the facility quality improvement program interventions added to nursing and CNA and evidence the Medical Director and care plan by Clinical Manager. Clinical Administrator had reviewed and approved all Manager/Weekend Supervisor to review inpolicies and procedures. Inservice and training service sheets and signatures daily x 2 weeks records including sign-in sheets for all nursing or longer as appropriate to monitor staff and non-nursing staff related to the new policies awareness. This will be reviewed by DON/ and procedures were provided. Interviews with ADON, Staff Development Nurse for nursing staff revealed nurses and certified compliance - random reviews, two times a nursing assistants were following the new policy week for 8 weeks and then every week. and procedure realted to accidents and supervision, alarms and facility quality Charge Nurses will update careplans and improvement. Observations revealed assistive CNA careplans if occurrence occurs and devices were properly applied and functioning. verbal/written in-services will be conducted certified nursing assistants were conducting and placed in communication for Clinical alarm checks, and facility communication books Manager/Weekend Supervisor review. were being utilized. ADON did a room check on equipment and environment on 6/19/13 ensuring proper The facility will remain out of compliance at a devices were in place and operational (floor Scope and Severity level "E"- no actual harm with mat, anti-tippers on w/c, soft helt and chair potential for more than minimal harm that is not alarm), immediate Jeopardy until it provides an acceptable plan of correction and the facility's correcive measures could be reviewed and evaluated by the Quality Assessment/

(F 329)

SS@D

Performance Improvement Committee.

UNNECESSARY DRUGS

483.25(I) DRUG REGIMEN IS FREE FROM

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including

(F 329)

No. 6764 P. 24
PRINTED: 07/11/2013
FORM APPROVED
OMB NO. 0938-0301

STATEMENT	OF DEFICIENCES	(VII DDDIADEDELISM MEMORIA				MR MO	0938-0391
AND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		445141	B, WING	·		1	R 09/2013
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		00,2010
BRADLE	Y HEALTH CARE & R	EHAB		2	910 PEERLESS RD		
	·			<u> </u>	LEVELAND, TN 37812		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES WIST RE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROPE DEFICIENCY)	BĒ	(X5) COMPLETION DATE
	by: Based on medical if all investigation do of manufacturer's re observations, review meeting minutes and for Sunshine Room to provide supervisit residents (#134, #3 #193, #2, #18) of fif failed to a apply sof manufacturer's insit of five soft belt restrailure placed four n #71) in immediate Jahren to a resident reviewed for fails. The sure any resident effective interventions when a effective was likely to failure to identify and interventions when a effective was likely to fails in immediate. The facility provided Allegation of Complitive interventions implemented Jeopardy on June 2.	record review, review of facility cumentation, interview, review of facility cumentation, interview, review ecommendations, a of facility restraint committee of review of the facility policy Guidelines, the facility failed on to prevent accidents for ten of the facility failed on the prevent accidents for ten of the facility failed on the prevent accidents for ten of the facility such one resident (#13) aints reviewed. The facility's esidents (#134, #37, #58, reopardy (a situation in which simpliance with one or more accidents injury, harm, impairment, but of eighteen residents he systematic failure to at risk for fails was provided as; failure to ensure atarm the and/or functional, and alimplement new current interventions were not oplace any resident at risk elepardy. an acceptable Credible and on June 29, 2013. A is, revealed the corrective if removed the Immediate	{F 3	23)	Treatment plan and falls interventions reviewed by DON. ADON, and MDS Coordinator on 6/20/13, with changes to plan on 6/24/13. DC 1:1, fall interventions that this resident are nonskid footwear, weighted blanket, sunshine room durin hours of operation when up in w/c and or daughter not present, bed and chair a Resident care plan was reviewed and ret assessed on 6/20/13 by DON with no chat that time. Resident was in sunshine rat the time (approximately 11am). Clarification of intervention on 6/24/13 added "when daughter not present" and chair alarm, eliminating verbage "when indicated". Resident care plan was review by MDS Coordinator on 6/24/13. Medi Director reviewed treatment plan, inclufalls interventions and reaffirmed plan on 6/25/13. Direct care staff was in-service of 6/18/13 by Clinical Manager regardit sunshine room attendance and taking resident there when up. Direct care stain-serviced by Clinical Manager on 6/24 and then in-service information placed in-service communication book and interventions added to nursing and ala CNA care plan by Clinical Manager. Climanager/Weekend Supervisor to review service sheets and signatures daily x 2 w or longer as appropriate to monitor staff awareness. This will be reviewed by DO ADON, Staff Development Nurse for compliance – random reviews, two time week for 8 weeks and then every week. Charge Nurses will update careplans and CNA careplans if occurrence occurs and verbal/written in-services will be conducted.	o care ons wife vident anges oom bed/ cal ding frare riced ag ff was /13 in the ceks f N/ s a	
XM CMS-25€	57(02-98) Previous Versions (Discolete Event ID: \$214612		Paci			Page 20.of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X9) DATE SURVEY A BUILDING COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID D PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) and placed in communication for Clinical {F 323} Continued From page 20 Manager/Weekend Supervisor review. ADON (F 323) Validation of the Credible Allegation of did a room check on equipment and Complaince was accomplished through medical environment on 6/19/13 ensuring proper record review, review of facility communication devices were in place and operational (bed books, observation and interview with front line alarm and chair alarm) staff and administrative staff. The facility provided #71 evidence of new policies and procedures related Treatment plan and falls interventions were to accidents and supervision, chair and bed alarms, the facility quality improvement program reviewed by DON, ADON, and MDS Coordinator on 6/20/13 with clarifications of and evidence the Medical Director and Administrator had reviewed and approved all bed against the wall and low bed. Fall policies and procedures. Inservice and training interventions for this resident are: bed against records including sign-in sheets for all nursing wall, low bed, floor mat, bed alarm, nonskid and non-nursing staff related to the new policies footwear, and soft belt while in w/c. DON and procedures were provided. Interviews with assessed resident, restraint was in place and no nursing staff revealed nurses and certified distress noted, and reviewed care plan on nursing assistants were following the new policy 6/20/13. Medical Director reviewed treatment and procedure resited to accidents and plan, including falls interventions and supervision, alarms and facility quality reaffirmed plan of care on 6/25/13. Direct care improvement. Observations revealed assistive staff was in-serviced on 6/24/13 by Clinical devices were properly applied and functioning, Manager and then in-service information certified aursing assistants were conducting placed in the in-service communication book alarm checks, and facility communication books and interventions added to nursing and CNA were being utilized. care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review in-The facility will remain out of compliance at a Scope and Severity level "E"- no actual harm with service sheets and signatures daily x 2 weeks or potential for more than minimal harm that is not longer as appropriate to monitor staff awareness. This will be reviewed by DON/ immediate Jeopardy until it provides an acceptable plan of correction and the facility's ADON, Staff Development Nurse for corrective measures could be reviewed and compliance - random reviews, two times a week for 8 weeks and then every week. evaluated by the Quality Assessment! Performance Improvement Committee. (F 329) 483.25(I) ĐRUG REGIMEN IS FREE FROM (F 329) UNNECESSARY DRUGS SS=D Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including FORM CMS-2587(02-99) Previous Versions Obsolela

If continuation sheet Page 21 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED 445141 B. WING 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (XS) COMPLETION PREFIX TAG DEFICIENCY Charge Nurses will update careplans and (F 323) Continued From page 19 CNA careplans if occurrence occurs and (F 323) This REQUIREMENT is not met as evidenced verbal/written in-services will be conducted and placed in communication for Clinical Based on medical record review, review of facility Manager/Weekend Supervisor review. fall investigation documentation, interview, review ADON did a room check on equipment and of manufacturer's recommendations, environment on 6/20/13 ensuring proper observations, review of facility restraint committee devices were in place and operational (low meeting minutes and review of the facility policy bed, floor mat, bed alarm). for Sunshine Room Guidelines, the facility failed to provide supervision to prevent accidents for ten **#9**5 residents (#134, #37, #58, #71, #95, #111, #52, Treatment plan and falls interventions were #193, #2, #18) of fifty-six residents reviewed and reviewed by DON, ADON, and MDS failed to a apply soft belt restraint according to Coordinator on 6/20/13 with clarification of manufacturer's instructions for one resident (#13) lotion with pump spout being removed (slick of five soft belt restraints reviewed. The facility's floor) and encouraged family regarding not failure placed four residents (#134, #37, #58, bringing that type of lotion and staff will #71) in immediate Jeopardy (a situation in which assess resident items with care on 6/24/13. the provider's noncompliance with one or more Pall interventions for this resident are nonskid requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, socks, keep environment clean of lotions or or death to a resident) of eighteen residents anything on floor. DON assessed the resident and reviewed care plan on 6/25/13, resident in reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided w/c, no distress noted. Direct care staff was effective interventions; fallure to ensure alarm in-serviced on 6/24/13 by Clinical Manager devices were in place and/or functional, and and then in-service information placed in the faiture to identify and implement new in-service communication book and interventions when current interventions were not interventions added to nursing and CNA care effective was likely to place any resident at risk plans by Clinical Manager. Clinical Manager/ for falls in Immediate Jeopardy. Weekend Supervisor to review in-service sheets and signatures daily x 2 weeks or The facility provided an acceptable Credible longer as appropriate to monitor staff Allegation of Compliance on June 29, 2013. A awareness. revisit on July 9, 2013, revealed the corrective This will be reviewed by DON/ADON, Staff actions implemented removed the Immediate Development Nurse for compliance - random Jeopardy on June 29, 2013. reviews, two times a week for 8 weeks and then every week. Charge Nurses will update Non-compliance for F-323 continues at an "E" careplans and CNA careplans if occurrence level citation. occurs and verbal/written in-services will be conducted and placed in communication for

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD OF

PRINTED: 07/11/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		445141	8. WING			R	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	_ 07	7/09/2013	
BRADL	EY HEALTH CARE & R	ЕНАВ		2910 PEERLESS RD CLEVELAND, TN 37312			
(X4) JD PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORPER		(X5) COMPLETION DATE	
(F 323)	Validation of the Cre Complaince was ac record review, review books, observation staff and administra evidence of new pol to accidents and su alarms, the facility of and evidence the Mi Administrator had re policies and procedu records including sig and non-nursing stal and procedures wer nursing staff reveale nursing assistants w and procedure realte supervision, alarms improvement. Obser devices were proper certified nursing assistant g assistant g were being utilized. The facility will remain	edible Allegation of complished through medical v of facility communication and interview with front line tive staff. The facility provided licies and procedures related pervision, chair and bed utility improvement program edical Director and redical Director and raining arish sheets for all nursing firelated to the new policies e provided, interviews with an nurses and certified are following the new policy and facility quality vations revealed assistive ly applied and functioning, stants were conducting accility communication books	{F 32	Clinical Manager/Weekend Supervices. ADON did a room check on equipment and environment on 6/20 chesuring proper devices were in place operational (bed and chair alarms). #111 Clinical Manager and DON/ADON: care plans with changes noted being alarm Dc'd 6/19/13, alarming seat be after assessment by Clinical Manager interventions for this resident are fall floor, nonskid shoes/slippers when or activity bundle at nurse's station whe bed alarm, and seat belt alarm. DON resident and reviewed care plan on 6/20 resident up and in w/c in sunshine rod Direct care staff was in-serviced on 6/20 Clinical Manager and then in-service information placed in the in-service communication book and intervention to nursing and CNA care plan by Clin Manager. Clinical Manager/Weekens Supervisor to review in-service sheets signatures daily x 2 weeks or longer and appropriate to monitor staff awareness.	eviewed itheir pad to 6/19/13. Fall mat on at of bed, a needed, \$856556d 24/13, om. 19/13 by and added ical land		
	potential for more the immediate Jeopardy acceptable plan of co conecive measures	evel "E"- no actual harm with an minimal harm that is not until it provides an execution and the facility's could be reviewed and		will be reviewed by DON/ADON, Sta Development Nurse for compliance – review, two times a week for 8 weeks's every week. Charge Nurses will updat careplans and CNA careplans if occur	random nd then e		
(F 329) 5S=D	UNNECESSARY DR	ement Committee. BIMEN IS FREE FROM UGS	{F 329	environment on 6/20/13 ensuring pro	on for review. at and		
	unnecessary drugs.	regimen must be free from An unnecessary drug is any cessive dose (including		devices were in place and operational mat, bed and seat belt alarms).	floor		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF GERICICALES AND PLAN OF CORRECTION AND PLAN OF CORRECTION A SULPANS THE PROVIDER OR SUPPLET BRADLEY HEALTH CARE & REHAB STREET ADDRESS, CITY, STATE, ZP CODE 2019 PERCENS IN TO SULPANS PROPRIESE ALM OF CORRECTION PROPRIESE ALM OF CORRECTION PROPRIESE ALM OF CORRECTION BY CONTROL PROPRIESE ALM OF CORRECTION SUCL D BE PROVIDER OR SUPPLET The RECULATORY OR LICE INEMTEVINE SPECIAL PROPRIESE ALM OF CORRECTION Based on medical record review, review of facility fall investigation documentation, interview, review of manufacturer's recommendations, observations, review of facility restraint committee meeting minites and review of the facility policy for Sunshine Room Guidelines, the facility falled to provide supervision for prevent and condens for ten residents (479.4, 477, 495.8, 471, 495.4, 4714, 452.4, 475.4,		KS FUR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STREET ADDRESS, CITY, STATE, ZP CODE 2910 PERCENT TAGE (EACH DEPICIONEY MEST BE PRECEDED BY PILL PRECEDITORY OR USE DEPITEYING INFORMATION) (F 323) Continued From page 19 This REGULATORY OR USE DEPITEYING INFORMATION) This REGULATORY OR USE DEPITEYING INFORMATION This REGULATORY OR USE DEPITEYING IN USE DEPITEYING IN USE DEPITEYING IN U	STATEMEN	T DF DEFICIENCIES	(X1) PROVIDER/SUPPLER/CLIA	(X2) MULT A. BUILDE	TIPLE CONSTRUCTION		(X3) DAT	E SURVEY
PRETADLETY HEALTH CARE & REHAB SUMMARY STATEMENT OF DEPICIENCIES 290 PERFLESS RD CLEVELAND, TN 37312 EACH DEPICIENCY MAST BE PRECEDED BY PLLL PREFIX PARTY OF DEPICIENCY MAST BE PRECEDED BY PLLL PREFIX PARTY OF DEPICIENCY MAST BE PRECEDED BY PLLL PREFIX PARTY OF DEPICIENCY MAST BE PRECEDED BY PLLL PREFIX PARTY OF DEPICE PARTY OF DEPARTY OF	NAME OF S		445141	B. WING		}		
(F 323) Continued From page 19 This REQUIREMENT is not met as evidenced by Based on medical record review, review of facility fall investigation documentation, introview, review of manufacturer's instructions for the facility pelicy for Sunshine Room Guidelines, the facility pelicy for Sunshine Room Guidelines, the facility pelicy for Sunshine Room Guidelines, the facility pelicy for Sunshine Room Guidelines, the facility pelicy for Sunshine Room Guidelines, the facility pelicy for Sunshine Room Guidelines, the facility pelicy for Sunshine Room Guidelines, the facility failed to provide supervision to prevent accidents for temperature pelicents (#134, #37, #38, #71, #35, #11, #82, #13, #2, #16) of fifty-six residents for temperature placed for unresidents (#134, #37, #36, #31, #36), #71) in immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, sentous injury, harm, impairment, or ceath to a resident) of eighten residents reviewed of facility and implement and failure to identify end implement new interventions wall at risk for falls was provided effective was likely to place and/or functional, and failure to identify end implement new interventions wall as the for falls was provided effective was likely to place any or functional, and failure to dentify end implement new interventions wall as the for falls was provided effective was likely to place any or functional, and failure to dentify end implement new interventions when current interventions were not effective was likely to place any or functional, and failure to dentify end implemented removed the immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on sune 29, 2013. A revisit on July 9, 2013, revealed the corprecive actions implemented removed the immediate Jeopardy on June 29, 2013. Non-compliance for F-323 continues at an "E-leaved of lately in the facility from Memorial Hospital after another "episode", resident art					STREET ADDRESS, CITY, STATE, ZIP CO.	<u>_</u>	071	<u>09/2013</u>
### STATEMENT OF DEPCIMENTS PROVIDERS READ DECIDENCY TASTS OF PROCEEDING BY PULL RECEIPTION FOR POPULATION	BRADLE	TY HEALTH CARE & R	EHAB		2810 PEERLESS RD	-		
(F 323) Continued From page 19 This REGUIREMENT is not met as evidenced by: Based on medical record review, review of facility fall investigation documentation, interview, review of manufacturer's recommendations, observations, review of the facility policy of Sunstine Room Guidelines, the facility restraint committee meeting minutes and review of the facility policy for Sunstine Room Guidelines, the facility replaced to provide supervision to prevent anotdents for ten residents (#124, #37, #58, #17, #58, #11, #52, #189, #2, #18) of fifty-six residents reviewed and falled to a apply soft beit restraint according to manufacturer's instructions for one resident (#134, #37, #58, #17, #58, #11, #52, #58), #27, #10 in immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, sentous righty, harm, impairment, or ceath to a resident at risk for falls was provided effective interventions; failure to ensure sidern devices were in piace and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place arry resident at risk for falls in Immediate Jeopardy. The facility provided an acceptable Credible Aflegation of Compiliance on June 29, 2013. Non-compiliance for F-323 continues at an "E" level citation.		SUMMARYSTA	TEMENT OF DEFICIENCIES	10				
(F 323) Continued From page 19 This REQUIREMENT is not met as evidenced by. Based on medical record review, review of facility fall investigation documentation, interview, review of manufacturer's recommendations, observations, review of facility restraint committee meeting minutes and review of the facility failed to provide supervision to prevent accidents for tenn residents (#134, #37, #58, #71, #95, #111, #52, #193, #2, #193, #2, #193) of fifty-six residents reviewed and failed to a apply soft belt restraint according to manufacturer's instructions reviewed. The facility's failure placed four residents (#134, #37, #55, #71) in immediate Jeopardy (s situation in which the provider's nencompliance with one or more requirements of participation has caused, or is likely to asuse, serious injury, harm, impairment, or death to a resident) of eighteen residents reviewed of facilitive to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. Non-compliance for F-323 continues at an "E" level citation.		REGULATORY OR U	MUST BE PRECEDED BY FULL MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE DEFICIENCY)	I CHOIN NO	SE ATE	COMPLETION DATE
		This REQUIREMENTS: by: Based on medical if fall investigation doctor manufacturer's recobservations, review meeting minutes and for Sunshine Room to provide supervision residents (#134, #37, #18) of fift falled to a apply soft manufacturer's instructure placed four refailure placed four requirements of partifically to cause, serior death to a resident reviewed for falls. The ensure any resident reflective interventions when called interventions when called in immediate. The facility provided interventions when called in the facility provided in falls in immediate. The facility provided interventions in immediate. The facility provided interventions in immediate. The facility provided in falls in immediate in falls in immediate in falls in immediate. The facility provided in falls in immediate in falls in falls in immediate in falls in falls in falls in falls in falls in falls	record review, review of facility rumentation, interview, review of facility rumentation, interview, review accommendations, or of facility restraint committee of review of the facility policy of facility restraint committee of review of the facility falled on to prevent accidents for ten or facility falled on the prevent accidents for ten or facility falled on the prevent accidents for ten or facility falled on the prevent accidents for ten or facility falled on the prevent according to belt restraint according to belt restraint according to belt restraint according to be untions for one resident (#13) and seldents (#134, #37, #58, espardy (a situation in which impliance with one or more icipation has caused, or is us injury, harm, impairment, and or eighteen residents to at risk for falls was provided at risk for falls was provided so, failure to ensure alarm and/or functional, and implement new urrent interventions were not place any resident at risk depardy. In acceptable Credible ince on June 29, 2013. A streepled the corrective removed the Immediate , 2013.	{F 32:	This resident's interventions we 6/24/13 by Clinical Manager an no clarifications required. DOI resident and care plan on 6/24/ checked bed wheels which were interventions for this resident a position, wheels locked, nonsking and house shoes within reach. I staff was in-serviced on 6/24/13 Manager and then in-service interventions added to nurse care plan by Clinical Manager. Manager/Weekend Supervisor to service sheets and signatures dain or longer as appropriate to more awareness. This will be reviewed. ADON, Staff Development Nurse compliance—random reviews, to week for 8 weeks and then every Charge Nurses will update carept CNA careplans if occurrence occurre	ad DON wassessed 13 and 10 cked. 13 and 10 cked. 13 and 15 cked. 15 and 16 cked. 16 cked. 16 cked. 16 cked. 16 cked. 16 cked. 16 cked. 16 cked. 16 cked. 16 cked. 16 cked. 17 cked. 18	rith I Fall low r, e sal rook CNA in- eks	

FOR

Event ID: 32HNr12

Facility ID: TN0601

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No 6764

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		P	RINTED: (z 7 07/11/201: PPROV <i>E</i> L		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	MB NO. 0 (X3) DATE 8 COMPL	<u>938-039°</u> Survey		
		445141	B. WING_	··	R	Navqa		
NAME OF PROVIDER OR SUPPLIER BRADLEY HEALTH CARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD CLEVELAND, TN 87312					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TÉMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE IS	(X5) COMPLETION DATE		
	Validation of the Cricomplaince was accepted review, review books, observation staff and administration accidents and supplications and procedures and procedures and procedures were nursing staff reveals nursing staff reveals nursing assistants vand procedure realt supervision, alarms improvement. Observices were proper certified nursing assistant and procedure realt supervision, alarms improvement. Observices were proper certified nursing assistant assistant checks, and for were being utilized. The facility will remain acceptable plan of corrective measures evaluated by the Quiperformance improved 483.25(i) DRUG RE	adible Allegation of acomplished through medical w of facility communication and interview with front line and interview with front line and interview with front line and interview with front line and interview with front line and procedures related pervision, chair and bed pervision, chair and bed pervision, chair and bed pervision, chair and bed pervision, chair and percent and externed and approved all ures. Inservice and training gnain sheets for all nursing aff related to the new policies a provided, Interviews with ad nurses and certified vere following the new policy and facility quality avalians revealed assistive riy applied and functioning, sistants were conducting acility communication books and out of compliance at a level "E"- no actual harm with an minimal harm that is not y until it provides an correction and the facility's could be reviewed and ality Assessment/ rement Committee. GIMEN IS FREE FROM	(F 329)	EMS at 7:55pm. Resident discharged to hospital. #2 Clinical Manager, DON/ADON review plan on 6/24/13. No changes or clarific were made at the time. Fall intervention this resident are nonskid socks. Direct staff in-serviced again on 6/24/13 by Cli Manager and then in-service information placed in the in-service communication and interventions added to nursing and care plan by Clinical Manager. Clinical Manager/Weekend Supervisor to review service sheets and signatures daily x 2 w longer as appropriate to monitor staff awareness. This will be reviewed by DO ADON, Staff Development Nurse for compliance – random reviews, two time week for 8 weeks and then every week. Nurses will update careplans and CNA careplans if occurrence occurs and verb written in-services will be conducted an placed in communication for Clinical Manager/Weekend Supervisor review. I care staff in-serviced regarding chair to when making phone calls, encouraging periods, husband education on asking for assistance, bed alarm and chair alarm. ADON did a room check on equipment environment on 6/19/13 ensuring propedevices were in place and querations of devices were in place and que	ed care ations ons for care inical on a book CNA vin- ceks or ON/ cs a Charge al/ d Direct sit in rest or			
S5=D	UNNECESSARY DI	RUG\$ [und vitali aidillib).				

FORM CMS-2587(02-99) Previous Versions Obsolete

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including

Event ID: 32HM12

Facility ID: TN0601

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 445141 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LEC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY #18 (F 323) Continued From page 19. Resident care plan reviewed on 6/24/13 by (F 323) This REQUIREMENT is not met as evidenced Clinical Manager, DON/ADON with clarifications made for rehab referral on Based on medical record review, review of facility 6/16/13. 6/20/13 ambient music at specific fall investigation documentation, interview, review times, offer toileting while awake. Fall of manufacturer's recommendations, interventions for this resident are bed against observations, review of facility restraint committee wall, bed alarm, chair pad alarm in w/c, meeting minutes and review of the facility policy nonskid socks, ambient music, anti-roll back for Sunshine Room Guidelines, the facility failed brakes on w/c. Direct care staff in-serviced to provide supervision to prevent accidents for ten again on 6/24/13 by Clinical Manager and residents (#134, #37, #58, #71, #95, #111, #52, then in-service information placed in the in-#193, #2, #18) of fifty-six residents reviewed and service communication book and failed to a apply soft belt restraint according to interventions added to nursing and CNA care manufacturer's instructions for one resident (#13) plan by Clinical Manager. Clinical Manager/ of five soft belt restraints reviewed. The facility's Weekend Supervisor to review in-service fallure placed four residents (#134, #37, #58, #71) in Immediate Jeopardy (a situation in which sheets and signatures daily x 2 weeks or the provider's noncompliance with one or more longer as appropriate to monitor staff requirements of participation has caused, or is awareness. This will be reviewed by DON/ likely to cause, serious injury, harm, impairment, ADON, Staff Development Nurse for or death to a resident) of eighteen residents compliance - random reviews, two times a reviewed for falls. The systematic failure to week for 8 weeks and then every week. ensure any resident at risk for falls was provided Charge Nurses will update careplans and effective interventions; fallure to ensure alarm CNA careplans if occurrence occurs and devices were in place and/or functional, and verbal/written in-services will be conducted fallure to Identify and implement new and placed in communication for Clinical interventions when current interventions were not Manager/Weekend Supervisor review. effective was likely to place any resident at risk ADON did a room check on equipment and for falls in immediate Jeopardy. environment on 6/19/13 ensuring proper devices were in place and operational (bed The facility provided an acceptable Credible alarms, chair pad alarms, anti-roll back brakes Allegation of Compliance on June 29, 2013. A on w/c). revisit on July 9, 2013, revealed the corrective #13 actions implemented removed the Immediate Resident review of restraint on 6/19/13 by

FORM CMS-2567(02-99) Previous Versions Obsolute

level citation.

Jeopardy on June 29, 2013.

Non-compliance for F-323 continues at an "E"

Event ID: 32HM12

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DON, Clinical Manager, and Rehab Director. Insured restraint on per manufacturer's

instructions. Posey Company conducted an

in-service on Monday, 6/24/13 regarding restraint placement and Rehab Director

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION DENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING COMPLETED 445141 8. WING 07/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) (D PROVIDER'S PLAN OF CORRECTION PRÉFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LEC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) continues to in-service CNAs, LPNs, RNs and Continued From page 20 {F 323} (F 323) Rehab staff on proper placement of restraint. Validation of the Credible Allegation of Medical Director and Administrator approved Complaince was accomplished through medical revised fall prevention policies (A) and record review, review of facility communication procedures including Falls Incident Packet books, observation and interview with front line (B), Alarm Policy (C), Tracking log (E) and staff and administrative staff. The facility provided checks (D) on 6/25/13. On 6/25/13, DON met evidence of new policies and procedures related with Clinical Managers, ADON, Staff to accidents and supervision, chair and bed Development Nurse, and MDS nurses to alarms, the facility quality improvement program review and revise above policies and forms and evidence the Medical Director and (A,B,C,D,E) and develop process for Administrator had reviewed and approved all policies and procedures. Inservice and training implementation and monitoring of these. records including sign-in sheets for all nursing Mandatory in-servicing on developed forms and non-nursing staff related to the new policies B,C,D and E to CNAs, LPNs, and RNs on and procedures were provided. Interviews with 6/25/13 by DON and/or Clinical Managers nursing staff revealed nurses and certified and Staff Development Nurse. No CNA, LPN, nursing assistants were following the new policy or RN will be allowed to work until in-serviced and precedure resited to accidents and on policies and procedures B, C, D, and E. supervision, alarms and facility quality In-services on policies B,C, D, and E will be improvement. Observations revealed easistive conducted on an ongoing basis with follow-up devices were properly applied and functioning, tests (F) and then follow-up tests (F) every 3 certified nutsing assistants were conducting months. In-services will be conducted by alarm checks, and facility communication books DON, ADON, Clinical Managers and/or Staff were being utilized, Development Nurse. The facility will remain out of compliance at a Scope and Severity level "E"- no actual harm with potential for more than minimal harm that is not immediate Jeopardy until it provides an acceptable plan of correction and the facility's correcive measures could be reviewed and evaluated by the Quality Assessment/ Performance Improvement Committee. (F 329) 483.25(i) DRUG REGIMEN IS FREE FROM (F 329) SS=D UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drag when used in excessive dose (including

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Event ID: 32HM12

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (XS) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 2. On 6/20/13, DON/ADON, Clinical {F 323} Continued From page 19 Managers and Staff Development Nurse This REQUIREMENT is not met as evidenced assessed all residents with falls to ensure appropriate interventions are in place. Based on medical record review, review of facility Residents at risk: 25 residents were identified fall investigation documentation, interview, review at risk on 6/25/13 having falls with the past 45 of manufacturer's recommendations. days. Three resident interventions were observations, review of facility restraint committee updated on nursing careplans after Clinical meeting minutes and review of the facility policy Manager/DON/ADON/Staff Development for Sunshine Room Guidelines, the facility failed Nurse reviewed. Updates charted by Clinical to provide supervision to prevent accidents for ten Manager and/or ADON/Staff Development residents (#134, #37, #58, #71, #95, #111, #52, Nurse. Direct care staff in-serviced by Clinical #193, #2, #18) of fifty-six residents reviewed and Manager and then in-service information falled to a apply soft belt restraint according to placed in the in-service communication book manufacturer's instructions for one resident (#13) and interventions added to nursing and CNA of five soft belt restraints reviewed. The facility's Clinical Manager/Weekend Supervisor to fallure placed four residents (#134, #37, #58, review in-service sheets and signatures daily x #71) in immediate Jeopardy (a situation in which 2 weeks or longer as appropriate to monitor the provider's noncompliance with one or more staff awareness. This will be reviewed by requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, DON/ADON, Staff Development Nurse for or death to a resident) of eighteen residents compliance - random reviews, two times a week for 8 weeks and then every week. Charge reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided Nurses will update careplans and CNA effective interventions; failure to ensure alarm careplans if occurrence occurs and verbal/ devices were in place and/or functional, and written in-services will be conducted and failure to identify and implement new placed in communication for Clinical interventions when current interventions were not Manager/Weekend Supervisor review. The effective was likely to place any resident at risk other 22 resident interventions already in place for falls in Immediate Jeopardy. are still current and effective. All devices were tested for functionality per ADON. The facility provided an acceptable Credible completed 6/23/13 and ongoing per policy Allegation of Compliance on June 29, 2013. A (D), chair and bed alarm policy were put into

FORM CMS-2567(02-99) Provious Versions Obsolete

level citation.

revisit on July 9, 2013, revealed the corrective

actions implemented removed the immediate

Mon-compliance for F-323 continues at an "E"

Jeopardy on June 29, 2013.

Evant ID: 32HM12

Facility ID: TNOS01

place (C), assessment of assistive device (E),

interventions will be determined per resident need and nurses have been given a falls

prevention - potential interventions (M) for

assistance to nurses when determining care for residents when need is evident by occurrence.

and alarm check forms (D). New

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Jul. 26. 2013 3:46PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764 RINIP 33//11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING_ COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 97312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX (XS) COMPLETION REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) On 6/25/13, DON/Clinical Mangers placed the {F 323} Continued From page 20 (F 323) falls incident packet (B) on each Nursing Validation of the Credible Allegation of station for use after staff in-servicing began on Complaince was accomplished through medical 6/25/13. record review, review of facility communication 3. Beginning 6/25/13 the charge nurse on each books, observation and interview with front line nursing unit will implement new interventions staff and administrative staff. The facility provided to be determined per resident need as evident evidence of new policies and procedures related by an occurrence. On 6/25/13 the Staff to accidents and supervision, chair and bed Development Nurse placed a falls prevention alarms, the facility quality improvement program potential interventions (M) for assistance to and evidence the Medical Director and Administrator had reviewed and approved all nurses when determining care for residents policies and procedures. Inservice and training when a fall occurrence happens. Nurses will records including sign-in sheets for all nursing update nursing careplans and CNA careplans and non-nursing staff related to the new policies if occurrence occurs. On 6/25/13, the DON and procedures were provided. Interviews with reviewed all incidents which includes falls nursing staff revealed nurses and certified within 72 hours for appropriate interventions, nursing assistants were following the new policy care planned with new interventions and and procedure realted to accidents and investigated accurately. supervision, elarms and facility quality 4. Clinical Manager/Weekend Supervisor to Improvement. Observations revealed assistive review in-service sheets and signatures daily devices were properly applied and functioning. until July 15, 2013, then weekly. DON and/ certified nursing assistants were conducting or ADON, Staff Development Nutse will alarm checks, and facility communication books review in-service sheets two times a week until were being utilized. August 26, 2013 and then weekly for compliance. CNA careplans and nursing The facility will remain out of compliance at a careplans regarding fall occurrences will be Scope and Severity level "E"- no actual harm with potential for more than minimal harm that is not reviewed by Clinical Mapager and MDS immediate Jeopardy until it provides an Coordinator with each occurrence. The outcomes of the monitoring tools put in place acceptable plan of correction and the facility's (Falls Incident Packet (B), falls intervention correcive measures could be reviewed and roster (K), alarm checks (D) will be reviewed evaluated by the Quality Assessment/ Performance Improvement Committee. by DON and/or ADON, Staff Development Nurse every two weeks beginning 7/15/13.

FORM CMS-2587(02-89) Previous Versions Obsolele

UNNECESSARY DRUGS

483.25(I) DRUG REGIMEN IS FREE FROM

Each resident's drug regimen must be free from

unnecessary drugs. An unnecessary drug is any

drug when used in excessive dose (including

(F 329)

\$5=D

Event ID: 32HM12

Facility ID: TN0801

his meetings.

Beginning at the 7/10/13 QAPI meeting,

outcomes of the falls, careplan, alarms and

intervention roster monitoring tools were

submitted by the DON and the Administrator

will report outcomes to the governing body at

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Jul. 26. 2013 3:47PM DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764 RIN P. 347/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 445141 A. WING R NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 (X4) AD PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG DATE DEFICIENCY) (F 329) Continued From page 21 Resident # 154 (F 329) duplicate therapy); or for excessive duration; or 1. Upon being notified on 5/20/13 of the without adequate monitoring; or without adequate 07/15/13 resident receiving Ampicillin, the charge indications for its use; or in the presence of nurse reported to Nurse Practitioner (NP) adverse consequences which indicate the dose and the antibiotic was changed to Ceftin – no should be reduced or discontinued; or any allergic reactions were noted. On 7/12/13, the combinations of the reasons above. DON placed a reminder note on the Emergency Drug Box to check for any Based on a comprehensive assessment of a allergies prior to administering any drug resident, the facility must ensure that residents taken from the Emergency Drug Box. who have not used antipsychotic drugs are not Licensed nurses were in-serviced (W) given these drugs unless antipsychotic drug regarding checking for allergies prior to therapy is necessary to treat a specific condition as diagnosed and documented in the clinical writing any order given for medication(s) and record; and residents who use antipsychotic checking sticker on front of chart beginning drugs receive gradual dose reductions, and 7/12/13 by the DON/ADON/Staff behavioral interventions, unless clinically Development. Nursing staff not attending contraindicated, in an effort to discontinue these will be in-serviced upon return to work by the DON/ADON/Staff Development Nurse. drugs. 2. On 7/12/13 all resident's medical records were rechecked by the DON/ADON/Clinical Managers for correct allergies posted on front of chart and medications ordered for allergies. The Pharmacy Services also checked their This REQUIREMENT is not met as evidenced database for resident profile medications for possible allergies. This was completed on Based on medical record review and Interview, 7/15/13. All resident medical records were the facility falled to ensure unnecessary accurate. medications were not administered to one 1.8 %. 3. Pharmacy Services will notify facility nurse resident (#154) of ten residents reviewed. before filling order if a medicine ordered is

FORM CMS-2567(02-99) Previous Versione Obsoleje

The findings included:

Obstructive Sleep Aprica.

Resident #154 was admitted to the facility on

February 14, 2013, with diagnoses including

Hyperlipidemia, Hypertension, Heart Disease,

Vitamin D Deficiency, Anemia, Dysphasia, and

Evani ID:32HM12

Facility (D: TN060)

include allergies listed

contraindicated. Beginning 7/15/13 the

DON/ADON/Pharmacy Consultant will monitor monthly for any incident or near

misses of administering medication that

Managers will review the infection control

sheet daily which is to be completed upon order of antibiotic, antiviral medication to

residents are allergic to. The ADON/Clinical

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Jul. 26. 2013 3:47PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764RINTP. 35711/2013 FORM APPROVED

AND PLANOF CORRECTION A BUNDING INVAME OF PROVIDER OR SUPPLIER HAME OF PROVIDER OF SUPPLIER HAME OF PROVIDER OF SUPPLIER HAME OF PROVIDER OF SUPPLIER HAME OF PROVIDER OF CORE HAME OF CORE	STATEME AND PLAN	NY OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	7825 MI	T THE	I CONTRACTOR OF	MB N	O. 0938-039
BRADLEY HEALTH CARE & REHAB STREET ADDRESS, CITY, STATE, ZP CODE 2910 PREPAIRESS, RD CLEVELAND, TN 37312 PROVIDER OR SUMMARY STATEMENT OF DEPICIPACES THE CLEVELAND, TN 37312 PROVIDER OR SUMMARY STATEMENT OF DEPICIPACES THE CLEVELAND, TN 37312 PROVIDER OR SUMMARY STATEMENT OF DEPICIPACES THE CLEVELAND, TN 37312 PROVIDER OR ACTION HEALTH OF CORRECTION (EACH DEPICIPACY MAST BE PRECEDED BY PULL REGULATORY OR LEG IDENTIFYING INFORMATION) (F 329) CONTINUED From page 22 Medical record review revealed the resident was allergic to Penicillin. Medical record review of a Laboratory Report dated May 18, 2013, revealed the resident had a Lifnary. Tract infection and the organism was susceptible to Ampicillin (antibiotic). Medical record review of a Telephone Order dated May 18, 2013, revealed the resident may be susceptible to Ampicillin (antibiotic). Medical record review of a Medication Administration Record (MAR) dated May 1, 2013, through May 31, 2013, revealed the resident received five doses of the Ampicillin 500 mg on May 18, 2013, at 3:00 a.m., and 9:00 p.m., May 19, 2013, at 3:00 a.m., and 9:00 p.m., May 19, 2013, at 3:00 a.m., and 9:00 p.m., May 19, 2013, at 3:00 a.m., and 9:00 p.m., and 9:00	P		IDENTIFICATION NUMBER:	A. BUILDING				ATE SURVEY
BRADLEY HEALTH CARE & REHAB SIMMARY STATEMENT OF DEPICENCIES (C4) ID SUMMARY STATEMENT OF DEPICENCIES (PROPER PROPER CONSTRUCTION PROFILE DEPOSITION OF LEVELAND, TM 37312 PROPER PROPER STATEMENT OF DEPICENCIES (F 329) (F 329) Continued from page 22 Medical record review revealed the resident was allergic to Penicillin. Medical record review of a Laboratory Report dated May 18, 2013, revealed the resident had a Urinary Tract Infection and the organism was susceptible to Ampicillin (arbibotic). Medical record review of a Telephone Order deteld May 18, 2013, revealed "start Ampicillin (arbibotic) when the state of the monthly monitoring outcomes to the scheduled August QAPI committee meeting. The Administration freedrations when resident received five dases of the Ampicillin 500 mg on May 18, 2013, revealed the resident received five dases of the Ampicillin foo mg on May 18, 2013, revealed the resident received five dases of the Ampicillin foo mg on May 18, 2013, are selected in resident received five dases of the Ampicillin foo mg on May 18, 2013, at 9:00 a.m., 300 p.m., and 9:00 p.m., Megical record review revealed no documentation of edverae drup reactions. Interview with the Assistant Director of Nursing (ADON) on June 18, 2013, at 9:30 a.m., in the ADON Office, confirmed the resident rad en allergy to Penicillin and received five doses of the Ampicillin and received five doses			445141	B. WING	;		ì	R
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(F 329) Continued From page 22 Medical record review revealed the resident was allergic to Penicillin. Medical record review revealed the resident was susceptible to Ampicillin (antipot from page 2) Medical record review of a Laboratory Report dated May 18, 2013, revealed the resident had a Urinary Tract infection and the organism was susceptible to Ampicillin (antipot from page 2) Medical record review of a Telephone Order deteid May 18, 2013, revealed "start Ampicillin (a type of penicillin) 500 mg (militigram) TID (three times a day) x (times) 7 days." Medical record review of a Medication Administration Record (MAR) dated May 1, 2013, through May 31, 2013, revealed the resident received five doses of the Ampicillin 600 mg on May 18, 2013, at 9:00 a.m., and 9:00 p.m., May 19, 2013, at 9:00 a.m., and 9:00 p.m., May 19, 2013, at 9:00 a.m., and 9:00 p.m., in the ADON Office, confirmed the resident had en altergy to Penicillin and received five doses of the Ampicillin and received five doses of the Ampicillin on May 18 and 19, 2013. (F 371) SS=F The Continued From page 22 Medical record review of a Laboratory Report dated May 18, 2013, at 9:00 a.m., and 9:00 p.m. May 19, 2013, at 9:00 a.m., and 9:00 p.m. May 19, 2013, at 9:00 a.m., and 9:00 p.m. May 19, 2013, at 9:00 a.m., and 9:00 p.m. May 19, 2013, at 9:30 a.m., in the ADON Office, confirmed the resident had en altergy to Penicillin and received five doses of the Ampicillin on May 18 and 19, 2013. (F 371) SS=F STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local author/likes; and (2) Store, prepare, distribute and serve food.	(X4) ID	SUMMARY STA	TEMENT OF DEPLOYERS		C	LEVELAND, TN 37312		
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	{F 371} SS≃F	Medical record reviet allergic to Penicillin. Medical record reviet dated May 18, 2013 Urinary Tract Infection susceptible to Ampire Medical record reviet dated May 18, 2013, (a type of penicillin) times a day) x (times Medical record reviet Administration Record through May 31, 201 received five doses of May 18, 2013, at 9:00 a.m. Medical record reviet of adverse drug reaction from the Medical record reviet of adverse drug reaction from May 18, 2013, at 9:00 a.m. Medical record reviet of adverse drug reaction from May 18, 2013, at 9:00 a.m. Medical record reviet of adverse drug reaction from May 18, 2013, at 9:00 proposed from considered satisfactor authorities; and (2) Store, prepare, dis	ew revealed the resident was ew of a Laboratory Report , revealed the resident had a on and the organism was cillin (antiblotic). ew of a Telephone Order , revealed "start Amploillin 500 mg (milligram) TID (three a) 7 days." ew of a Medication rd (MAR) dated May 1, 2013, 3, revealed the resident of the Ampicillin 500 mg on 0 p.m. and 9:00 p.m., May a., 3:00 p.m., and 9:00 p.m. w revealed no documentation tions. sistant Director of Nursing 2013, at 9:30 a.m., in the led the resident had an of received five doses of the and 19, 2013. CURE, ERVE - SANITARY sources approved or y by Federal, State or local		1. m de de Oo	A modified form is in use until new for is received. (Tentative date 7/26/13) Results of the monitoring will be report weekly at the morning meeting. 4. Beginning August 2013, the DON we report any medication errors dealing administration of medications when resident has an allergy and the monthly monitoring outcomes to the scheduled August QAPI committee meeting. The Administrator will report to the govern body concerning these monitoring outcomes on a quarterly basis or more often as necessary. On June 10, 2013 the Dietary manager and staff cleaned the white dried ebris underneath the mixer head and blacebris inside the ice machine. In June 12 the Dietary Manager conduction on one in-service with Dietary Aide and #3 concerning washing hands and what and #3 concerning washing hands and what and #3 concerning washing hands and what are the content of the concerning washing hands and what are the concerning washing hands and what are the concerning washing hands and what are the concerning washing hands and what are the concerning washing hands and what are the concerning washing hands and what are the concerning washing hands and what are the concerning washing hands and what are the concerning washing hands are the concerning wash	ried vill vith class	7/18/13

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764*RINP. 367/11/2013 FORM APPROVED

STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	T		FORM APPROVED MB NO. 0938-0391
	N OF CORRECTION	DENTIFICATION NUMBER:	(X2) MULTI A. BUKLDIN	PLE CONSTRUCTION	(X3) DATE SURVEY
<u></u>	,	445141	j		COMPLETED
NAME O	PROVIDER OR SUPPLIER	443141	B. WING		R
	EY HEALTH CARE & R	EHAB	5	TREET ADDRESS, CITY, STATE, ZIP CODE 2910 PEERLESS RD	07/09/2013
OKALID	SUB-MATTER OF THE			CLEVELAND, TN 37312	
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROXIMATION OF THE APPROXIM	
	This REQUIREMENT by: Based on observation and interview, the fact storage of equipment maintain food temper The findings included Observation with the (CDM) on June 10, 20 kitchen, revealed the debris underneath the machine had a black machine had a black machine. Interview with mixer and the ice machine had a black machine, revealed the kitchen, revealed of the kitchen, revealed of the Daservation revealed awater pitcher and start stopped the DA from utile Surveyor told the Conterview with DA #2 cont	T is not met as evidenced on, review of facility policy, illity falled to provide sanitary in the kitchen and failed to atures. Certified Dietary Manager of 13, at 10:15 a.m., in the mixer had a white dried mixer had a white dried mixer head and the ice debris inside the ice ith the CDM confirmed the whine were dirty. 10, 2013, at 10:35 a.m., in Dietary Aide (DA) #2 ar on the floor, picked it up, helf for use. Continued a second DA retrieved the ed to use it. The CDM sing the water pitcher after incident. Onfirmed the water pitcher or and placed back on the 2, 2013, at 11:50 a.m., in		2. On 6/12/13, the Administrator met the Dietary Manager to review the deficiencies and regulatory requirement. The following actions were developed to ensure appropriate cleaning of equipment infection control practices and food temperatures: On 7/2/13 (#6) the Dietary Manager provided special training to the Dietary on procedures for daily cleaning at endocaday, chemicals to use and techniques, dropping items in floor, and maintaining food temperatures at or above 140 degree Fahrenheit for hot food items and at or below 41 degrees Fahrenheit for cold item Policy (#7) reviewed and revised: Kitche Sanitation, infection control, and Food Temperatures logs, revised the weekly equipment cleaning schedule. On 7/2/13 (#6) the Dietary Manager conducted mandatory in-services with Dietary staff on new guidelines of the weekly equipment cleaning schedule (#8) and standard precautions. A second in-service scheduled for July 18, 2013 (#9) to be conducted by a GFS representative on standard precautions. No employee will be able to return to work until they have been in-serviced on the above policies by the Dietary Manager. The Dietary Manager developed and approved by the Administrator new food temperature logs for temperatures to be recorded before.	twith ts. to ent, staff of ges as. in
į	doves without washing	ITA ITAB VIII A A A A A A A A A A A A A A A A A	i	furing, and after tray line on 7/2/13. (#10) The Dietary staff was in-serviced	

No. 6764-RINP. 377/11/2013 FORM APPROVED

STATEM	NT OF DEFICIENCIES	G MEDICAID SERVICES			_	FQ.	KM APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY	
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NAME O	PROVIDER OR SUPPLIER					11	07 <u>/</u> 09/2013
BRAD	LEY HEALTH CARE & R	EHAB		2	REET ADDRESS, CITY, STATE, ZIP CODE 810 PEERLESS RD		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	 -		LEVELAND, TN 37312		
PRÉFI) TAG	(EACH DEFICIENCY REGULATORY OR LE	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	'	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Pr-	(X6) COMPLETION DATE
{F 371	This REQUIREMEN by: Based on observation and interview, the far storage of equipmen maintain food temps The findings included Observation with the (CDM) on June 10, 2 kitchen, revealed the debris underneath the machine had a black machine. Interview with machine had a black machine. Interview with the kitchen, revealed dropped a water pitch placed it back on the observation revealed water pitcher and star stopped the DA from uthe Surveyor told the (Interview with DA #2 c was dropped on the fit shelf for use.) Observation on June 1 the kitchen, revealed fit dumpster and returned	T is not met as evidenced on, review of facility policy, cility failed to provide sanitary in the kitchen and failed to ratures. It: Certified Dietary Manager 013, at 10:15 a.m., in the mixer had a while dried on mixer head and the ice debris inside the ice with the CDM confirmed the chine were dirty.	{F 37	I see on oa ArimA 4. wisco According Co. 8/i Jul rep	by the Dietary Manager on July 2, 2013 stop the line in the event that the potent hazardous food is not at a proper temperature. Potentially hazardous food be brought to proper temperature before resuming the tray line. 3. To ensure the deficient practice does reoccur, beginning 7/15/13 the Administrator will begin checking Dietar Services daily for three weeks then weeks until substantial compliance has been obtained with the cleaning policies. The Dietary Manager will initial the cleaning schedule daily upon observance of the cleaniness of the equipment and compliant the cleaning schedule. The dietary manager, Asst Mgr or cook will weekly observe food temperatures being recordent review temperature forms twice week my issues identified will be evaluated, investigated and an action plan put into promediately and reported to the administrator. The dietary manager, Asst Mgr or cook ill monitor the equipment cleaning thedule weekly, conduct weekly standard recautions audits, and review food imperature logs weekly to ensure impliance then report outcomes to the dministrator monthly and at every QAP mmlttee meeting beginning with the 14/13 QAPI meeting which will review by outcomes. The Administrator will poort all monitoring outcomes at the next everning Body Meeting.	to ially lis to a not ry y	
	putting clean dishes a	vay. Interview with DA #1	İ				

Jul. 26. 2013 3:48PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764-RINP. 387/11/2013

FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (XZ) MULTIPLE CONSTRUCTION (X3) DATE BURVEY A. BUILDING COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID. REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG TAG (765) COMPLETION DATE DEFICIENCY) {F 371} Continued From page 24 Attachments: {F 371} confirmed the hands were not washed before #6 Inservice Record of Attendance 7/2/13, handling clean dishes. Equipment, Handwashing, and Temperatures #7 Policy and Procedure Equipment, Observation with the CDM on June 10, 2013, Infection Control, Hot Foods from 11:50 a.m. until 12:15 p.m., revealed serving # 8 Weekly Cleaning Schedule line 1 food temperatures were: ground meat balls # 9 GPS Rep In-Service 132 degrees; white gravy 118 degrees; serving #10 Food Temperature Logs line 2 food lemperatures were: ground chicken 130 degrees; meat balls 130 degrees; puree spaghetti 116 degrees; and white gravy 130 degrees. Review of facility policy, Food Temperatures, (not dated) revealed "...will serve food in a safe temperature range...hot foods must be 140 degrees and above..." Interview with the CDM at the time of the observation confirmed the food temperatures were not the correct temperature and seventy-five percent of the residents had been served. 483.60(a),(b) PHARMACEUTICAL SVC -{F 425} Resident # 134, #178 07/15/13 (F 425) 8S≈D ACCURATE PROCEDURES, RPH 1. The DON, Pharmacy Consultant, ADON, The facility must provide routine and emergency and Clinical Manager reviewed MARS on drugs and biologicals to its residents, or obtain 7/11/13 for resident # 134 and resident # 178 them under an agreement described in for the month of June 1-30, 2013. All meds §483.75(h) of this part. The facility may permit were administered in a timely manner as unlicensed personnel to administer drugs if State ordered. Licensed Nurses were in-serviced law permits, but only under the general (Q) regarding timely administration of supervision of a licensed nurse. medication when new order is written by A facility must provide pharmaceutical services physician/Nurse Practitioner beginning (including procedures that assure the accurate 7/12/13 by the DON/ADON/Staff acquiring, receiving, dispensing, and Development. Nursing staff not attending will administering of all drugs and biologicals) to meet be in-serviced upon return to work by the the needs of each resident. DON/ADON/Staff Development Nurse.

Jul. 26. 2013 3:48PM

DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764RIMP. 397/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING_ COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2010 PEERLESS RD CLEVELAND, TN 37312 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION TAG DATE {F 425} Continued From page 25 2. Beginning 7/12/13, the Clinical Mangers (F 426) audited all physician orders written for the The facility must employ or obtain the services of month of July for medication administered a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy timely using a "Medication Monitoring Log" (X). There were no medications services in the facility. administered untimely. 3. As of 7/1/13, the 11p-7a nurse on each wing will audit charts nightly for any new orders to ensure orders are correctly checked This REQUIREMENT is not met as evidenced and new medications are administered within 4 hours of order or physician notified Basad on medical record review and interview, when this time frame cannot be met. Clinical the facility failed to administer medications timely Manager will notify DON as appropriate of for two residents (#134, #178) of ten residents any pertinent findings in the morning reviewed. meeting. Beginning the week of 7/15/13, the Pharmacy consultant will audit five charts on The findings included: each wing per week for one month to ensure that medications are administered timely. A Resident #134 was admitted to the facility on list of available medications in the June 17, 2009, with diagnoses including Anxiety, emergency/narcotic box on Wing 2 and Depressive Psychosis, and readmitted August 13, Central Supply will be provided to all nurses 2013, with diagnoses including right femur by 7/15/13 and placed in appropriate fracture. notebooks. (Y) Medical record review of a Nurse's Note deted 4. Beginning Aug 2013, the DON will report July 9, 2013, at 4:00 p.m., revealed "... Urine C&S timely administering medication monitoring (culture and sensitivity) called to Dr. outcomes at the scheduled 8/14/13 QAPI (doctor)...T.O. (telephone order) Ampicillin committee meeting. The Administrator will (antiblotic) 500 mg (milligram) QID (four times per report to the governing body concerning day) x (times) 5 days...placed on MAR these monitoring outcomes on a quarterly (medication administration record), faxed to basis or more often as necessary. pharmacy..." Attachments: Timely Medication Administration Log (X) Medical record review of the Medication Nursing In-service (Y) Administration Record (MAR) dated May 1, 2013 Medication List for Emergency Box through May 31, 2013, revealed Ampicillin 500

2013.

mg first dose given at 12 midnight on May 9.

and Central Supply (Y)

No. 6764 P. 40

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES <u>OMB NO. 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED R 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 SYREET ADDRESS, CITY, STATE, ZIP CODE **ERADLEY HEALTH CARE & REHAB** 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION PREFIX TAG TAG DATE DEFICIENCY) (F 425) Continued From page,26 (F 425) interview with the Director of Nursing on June 13, 2013, at 2:35 p.m., in the conference room, confirmed the facility had falled to administer the antibiotic for a Urinary Tract infection timely and the Ampicillin had been available for immediate administration in the pharmacy back up box. Resident #178 was admitted to the facility on August 11, 2011, with diagnoses including Deep Vein Thrombosis, Scoliosis, Glaucoma, and Chronic Pain. Medical record review of a Provider Note dated May 22, 2013, revealed "...Nsg (nursing) concerned re: (regarding) pt (patient) c/o (complaint of) ears feeling stopped up and decreased hearing..." Medical record review of a Physician's Order dated May 22, 2013, revealed "...Debrox (ear wax drops) 5 gits (drops) R (right) ear BID (twice daily) x (times) 4 days... Medical record review of a Nurse's Note dated May 22, 2013, at 1:00 p.m., revealed "...N.O (new order)...Debrox 5 gtts R ear BID x 4 days...* Medical record review of the MAR dated May 1, 2013 through May 31, 2013, revealed the first dose of Debrox ear offs was given on May 23, 2013, at 9:00 p.m. Interview with the Director of Nursing on June 18, 2013, confirmed the facility had failed to administer the ear drops until thirty-two hours after the Physician had ordered the ear drops and the ear drops were immediately available in the pharmacy back up box.

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 67649RINP. 41/7/11/2013 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/GUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING_ COMPLETED 448141 B. WING R NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, 2IP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG (XS) COMPLETION DEFICIENCY) 483,65 INFECTION CONTROL, PREVENT {F 441} 1. All shower rooms were scrubbed on {F 441} SPREAD, LINENS SS≃F 6/11/13 by Environmental Services to remove 07/15/13 debris noted on survey. On 6/11/13 tubing and The facility must establish and maintain an disposable bubble humidifiers for residents # Infection Control Program designed to provide a 106 and #203 were changed by Clinical safe, sanitary and comfortable environment and managers and dated. Licensed nurses and to help prevent the development and transmission CNAs were in-serviced regarding hand of disease and infection. hygiene, checking and changing 02 tubing and humidifiers, and reporting compromised (a) Infection Control Program showers to Environmental Services Director (Z) The facility must establish an Infection Control beginning 7/15/13 by the DON/ADON/Staff Program under which it -Development. Nursing staff will be in-serviced (1) investigates, controls, and prevents infections upon return to work by the DON/ADON/Staff in the facility; Development Nurse. A post-test will (2) Decides what procedures, such as isolation, conducted by the Staff Development Nurse should be applied to an individual resident; and and/or DON/ ADON. (3) Maintains a record of incidents and corrective actions related to infections. 2. All shower rooms were inspected by the Administrator and Environmental Services (b) Preventing Spread of Infection Supervisor on 6/11/13 and 6/12/13 for (1) When the Infection Control Program compliance and no concerns were noted. determines that a resident needs isolation to prevent the spread of infection, the facility must 3. Shower rooms will be cleaned daily and isciste the resident, monitored weekly by Environmental Services (2) The facility must prohibit employees with a Director for 4 weeks or until substantial communicable disease or infected skin lesions compliance has been met. Beginning 7/15/13 from direct contact with residents or their food, if the Clinical Managers will monitor Q2 direct contact will transmit the disease. concentrators for tubing and humidifiers are (3) The facility must require staff to wash their checked, changed, and dated weekly for 4 hands after each direct resident contact for which weeks and report any findings to the DON. hand washing is indicated by accepted Shower rooms will be monitored weekly by professional practice. Environmental Services Director and/or lead housekeeper to ensure compliance of infection (c) Linens control prevention. Results of the monitoring Personnal must handle, store, process and will be reported to the DON weekly and to the transport linens so as to prevent the spread of scheduled 8/14/13 QAPI committee meeting. infection. On 7/15/13, the Clinical Managers will observe hand hygiene in dining rooms and resident care areas using a monitoring tool (Z) for observation in dining

Jul. 26. 2013 3:49PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764 RINP. 42/7/11/2013 FORM APPROVED

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IDENTIFICATION NUMBER:			IDENTIFICATION NUMBER: A. BUILDING			LE COMSTRUCTION	(X3) D	(X3) DATE BURVEY COMPLETED	
			445141	B. WING				R	
I	NAME ()	PROVIDER OR SUPPLIER		1 2. 44/140	, =		1 0	7/09/2013	
I	BRADI	LEY HEALTH CARE & R	ЕНАВ] 4	REET ADDRESS, CITY, STATE, ZIP CODE 2810 PEERLESS RD	<u> </u>		
ľ	(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES			CLEVELAND, TN 37312			
	PREFD TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE	
		This REQUIREMENT by: Based on observation and interview, the faction and sanitary endered wing 3, Wing 4) of endered failed to follow senitation residents (#106, reviewed; and failed manner. The findings included manner. Observation and intervitories in June 11, 2013, from the Unit Manager confirmed the bottom of the show Manager confirmed the debris. Observation and intervitories in June 11, 2013, from the bottom of the show Manager confirmed the debris. Observation and intervitories in June 11, 2013, from debris in June 11, 2013, from the bottom of the show manager confirmed the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the black definition of the shower was confirmed the shower was co	it is not met as evidenced on, review of facility policy, cility failed to maintain a nylronment in six (Wing 1, light shower rooms observed; ly oxygen administration for #230) of fifty-six residents to serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is serve food in a sanitary it is substance on the tile and com of the shower stall area. The tile and grout around the shower rooms, revealed the shower room had black it is shower room had black it is shower food p.m., of the shower food p.m., of the shower food p.m., of the shower food p.m., of the shower food p.m., of the shower food p.m., of the shower food p.m., of the showed black debts on the it is sanitary.	{F 4	413	room and resident care areas one day for 4 weeks or until substantial compl achieved. Results will be reported to DON upon completion of observation 4 Beginning Aug 2013, the DON will to the QAFI committee monitoring outcomes concerning environmental cleaning, changing O2 tubing and humidifiers, and hand hygiene.	a week iance is he		
	- 1	OUNCE MANU FILE 1100L'	mitted to the facility on July			•			
	<u>أ</u>		or one received but notice		1			l	

No. 6764 P. 43

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/11/2013
FORM APPROVED
OMB NO. 0938-0391

ULTIPLE CONSTRUCTION
(X3) DATE SURVEY
DING

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445141	B. WING			R		
}	ROVIDER OR SUPPLIËR Y HEALTH CARE & R	EHAB		STR 29	REET ADDRESS, CITY, STATE, ZIP CODE 910 PEERLESS RD CLEVELAND, TN 37312	<u>i 07</u>	7/09/2013	
(X4) ID PREFIX TAG		Tement of Deficiencies Must be preceded by full ac identifying information)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE)	7 6 8 7	COMPLETION DATE	
}	Hyperlipidemia, Alzi Anxiety Disorder, Disorder, Disorder, Disorder, Disorder, Disorder, Disorder, Disorder, Disorder, Disorder, Disorder, Disorder, 23, 200 disposable bubble hays, label and date Observation on June revealed resident #1 flowing at 2 liters per observation revealed humidifier and pasallabel containing a definiterview with LPN # resident's room at 10	loses of Diabetes Mellitus, neimer's Disease. Dementia, apression, and Bipolar licy, Oxygen Concentration, 28, revealed "change numidifier and tubing every 7" e 10, 2013, at 10:13 a.m., 106 in the room with oxygen r nasal cannula. Continued if a disposable bubble cannula tribing without a site when changed.	{F 4	41)				
	containing a date who containing a date who containing a date who have 3, 2013, with discrete 3, 2013, with discre	r were without a label len changed. admitted to the facility on agnoses of Pneumonia, ge Renal Disease, Renal controlled Dlabetes Mellitus, re Ulcer, Paralysis Agitans, eumothorex, Hypertension, ase, Ischemic lai Fibrillation, Asthma, Disease, and Gastric Reflux 10, 2013, at 10:13 a.m., 26 in the room with oxygen resal cannula.		-				

No. 6764 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING _ 445141 R B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIGIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX TAG (X5) COMPLETION TAG DATE DEFICIENCY) (F 441) Continued From page 30 (F 441) label containing a date when changed last. Interview with LPN #2 ,on June 10, 2013, in the resident's room at 10:40 a.m., confirmed the tubing and humidifier did not have a label containing a date when changed last. Observation of Wing I, on June 10, 2013, from 11:45 a.m. until 12:10 p.m., revealed the Care Assistant Technician (CAT) #1 placed clothing protectors on twenty-four residents, removed one resident's hat and rubbed his head, scratched self on ear, end passed six dinner trays, without washing hands. Interview with CAT #1, on June 10, 2013, at 12:33 p.m., at the Wing 1 Nurse's station, confirmed CAT #1 had falled to wash hands between the resident contact, touching self, and prior to passing the dinner trays. (F 490) 483,76 EFFECTIVE (F 490) ADMINISTRATION/RESIDENT WELL-BEING SS≃E Resident # 134, # 37, #58, #71, #95, #111, #52, 07/15/13 #193, #2, #18 and #13 A facility must be administered in a manner that enables it to use its resources effectively and On 6/25/13, the Administrator, efficiently to attain or maintain the highest Medical Director, and DON reviewed and practicable physical, mental, and psychosocial approved all the new and revised policies and well-being of each resident. procedures. (B,C,D,E) On 6/22/13, the Administrator engaged an outside consultant to assist with the development of the action

FORM CMS-2567(02-99) Previous Versions Obsolete

by:

This REQUIREMENT is not met as evidenced

Based on medical record review, facility policy

system to ensure supervision and an environment

review, review of manufacturer's instructions,

free of accident hazards. The facility's failure

administration falled to provide an effective

observations, and interview, the facility

Event ID:32HM12

Facility.ID: TN0801

If continuation sheet Page 31 of 39

plan and the implementation of the plan. On

6/25/13, the Administrator reviewed the

deficiencies with the Governing Body. On

6/25/13, the Administrator had previously

approved two nurse managers to attend the

6/25/13 QAPI training session conducted by

QIO in Knoxville, TN. (See attachment (O).

Jul. 26. 2013 3:50PM DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764-RINIP. 457/11/2013 FORM APPROVED

STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY a. Building COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X6) COMPLETION TAG DATE DEFICIENCY) On 6/25/13, the Administrator and DON (F 490) Continued From page 31 (F 490) revised the QA plan and developed a resulted in multiple fails and placed four residents standardized agenda and trending reports (1) (#134, #37,#71, #58) in Immediate Jeopardy (a for monitoring Incidents, Accidents, situation in which the provider's noncompliance has caused, or is likely to cause serious injury. Infection Control, Restraints, Medication Errors, and Resident alarms. A called QAPI harm, impairment, or death) of eighteen residents meeting was conducted 6/25/13 to approve reviewed. The systematic failure to ensure any resident at risk for falls was provided effective the plan, revised policies (J) and review established tools for monitoring. The interventions; failure to ensure alarm devices Administrator reviewed the allegations of were in place and/or functional, and failure to identify and implement new interventions when compliance plan for the IJ tags received current interventions were not effective was likely during the recent survey at this meeting. The to place any resident at risk for falls in immediate Administrator will attend QAPI meetings and Jeopardy. receive reports for review to ensure compliance and the information from QAPI The facility provided an acceptable Credible trends reports will be communicated to Allegation of Compliance on June 29, 2013. A Governing Body by the Administrator. revisit on July 8-9, 2013, revealed the corrective 3. On 6/25/13 and 7/15/13, the DON, ADON actions implemented removed the immediate and/or QAPI Coordinator will monitor falls Jeopardy on June 29, 2013. and fall interventions, alarms, notification of Physician of lab results, changing O2 tubing Non-compliance for F-490 continues at an "E" and humidifiers timely and with dates, hand level citation. bygiene in dining and resident care areas, administering medications timely, medication Validation of the Credible Allegation of administered when allergy present, accurate Compliance was accomplished through medical MDS assessments and careplans, dignity in record review, observation and interview with front line staff and administrative staff. The facility delivery of trays, placing of clothing provided evidence of new policies and protectors, restraints, and reporting incidents procedures related to Accidents and Supervision, of unknown origin to State. The DON and/or Chair and Bed alarms, the System Improvement Clinical Managers will monitor performance Report and review of evidence the Medical of staff on a monthly basis for 90 days Director and Administrator had reviewed and concerning falls intervention, compliance approved all policies and procedures. Inservice with revised falls prevention program. This and training records including sign-in sheets for began on 6/25/13. Beginning 6/25/13 the all nursing and non nursing staff related to the Administrator will ensure the daily/weekly/ new policies and procedures were provided. monthly monitoring is occurring as stated for Interviews with nursing staff revealed nurses and compliance of deficiencies and report finds to certified nursing assistants were following the QAPI committee and governing body.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 (X4) ID PREFIX SLIMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ED PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 4. Beginning 6/25/13 the Administrator will (F 490) Continued From page 32 conduct timely QAPI meetings quarterly and {F 490} new policy and procedure related to the new fall will also conduct these meetings more often if and prevention policy, and alarm policy. Interview needed to evaluate compliance with policies with the Administrator revealed the Administrator and procedures as well as the monitoring tools met with the Governing Body members to discuss established. The Administrator will report to the status of the survey. Interview and the governing body. documentation review with the Administrator revealed with help of an outside consultant the Administrator and the Director of Nursing developed a standardized agenda and trending reports for monitoring falls and alarms. The facility will remain out of compliance at a Scope and Severity level "E"- a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm that is not immediate Jeopardy, until it provides an acceptable plan of correction and the facility's corrective measurers could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee. {F 501} 483.75(I) RESPONSIBILITIES OF MEDICAL {F 501}. Resident # 134, # 37, #58, #71, #95, #111, SS=E DIRECTOR 07/15/13 #52, #193, #2, #18 and#13 The facility must designate a physician to serve 1. The Medical Director reviewed the as medical director. treatment plans and falls interventions of each resident on 6/25/18 for effectiveness The medical director is responsible for and any needed changes to their plan of care. implementation of resident care policies; and the This was recorded in the progress note of coordination of medical care in the facility. each resident. Beginning on 6/24/13, the DON, Administrator, and Medical Director reviewed and revised the policies and This REQUIREMENT is not met as evidenced procedures as follows: Falls Prevention by: Program with forms and Chair and Bed Based on medical record review, facility policy Alarm. On 6/24/13, the Healthcare review, review of manufacturer's instructions. Consultant reviewed the Federal and State observation, and interview, the Medical Director responsibilities required for the Medical falled to provide oversight and participate in the Director with the DON, Administrator, and

Medical Director.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 6764 P. 47
PRINTEU: U//11/2013
FORM APPROVE

STATEMENT OF DESCRICIONES AND PLAN OF CORRECTION AND PLAN OF CORRECTION A 45141 ASSUMBLEY HEALTH CARE & REHAB CLEVELAND, TN 37312 STREET ADDRESS, OITY. STATE, 2IP CODE 2910 PERCHENCES RD CLEVELAND, TN 37312 STREET ADDRESS, OITY. STATE, 2IP CODE 2910 PERCHENCES RD CLEVELAND, TN 37312 CLEVELAND, TN 37312 CONTINUED From page 38 Gevelopment of policies and procedures to ensure an effective system for supervision of residents at risk for falls. The facility's failure placed four residents (#134, #37, #58, #71) in immediate aboptardy (a situation in which the provider's noncompliance has caused, or is likely to cause serious injury, harm, impairment, or death) of eighteen residents reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to tientify and implement new interventions when not effective was likely to place any resident at risk for falls in immediate The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8-9, 2013, revisit on July 8-9, 2013, revisit on July 8-9, 2013, averailed the corrective actions implemented are provided to the corrective any resident at risk for falls in immediate Jeopardy. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8-9, 2013, revisited the immediate Jeopardy on June 29, 2013. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8-9, 2013, revisited the immediate Jeopardy on June 29, 2013. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8-9, 2013, revisited the immediate Jeopardy on June 29, 2013. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisition June 20, 2013. The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. The facil	CENTE	KS FOR MEDICARE	& MEDICAID SERVICES		,		WENCOVED AND
AMME OF PROVIDER OR SUPPLIER BRADLEY HEALTH CARE & REHAB (XA) ID PREFIX TAGE SUMMAY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 501) Continued From page 33 development of policies and procedures to ensure an effective system for supervision of residents at risk for falls. The facility failure placed four residents (#134, #37, #38, #71) in immediate Jeopardy (a situation in which the provider's noncompliance has caused, or is likely to cause serious hylury, harm, impairment, or death) of elightsen residents reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure slarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in immediate Jeopardy. The facility provided an acceptable Credible Altegation of Compliance on June 29, 2013. A revisit on July 8-9, 2013, revealed the corrective actions implemented removed the immediate Jeopardy on June 29, 2013.	STATEMEN!	T OF DERICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		RPLE CONSTRUCTION	(XS) DAT	E SURVEY
STREET ADDRESS, GIT, STATE, 2IP CODE 2810 PERFLESS RD CLEVELAND, TN 37312 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 501) Continued From page 33 development of policies and procedures to ensure an effective system for supervision of residents at risk for falls. The facility's failure placed four residents (#194, #37, #58, #71) in immediate Jeopardy (a situation in which the provider's noncompliance has caused, or is likely to cause serious injury, harm, impeliment, or death) of eighteen residents reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in immediate Jeopardy. The facility provided an acceptable Credible Allegation of Complience on June 29, 2013. A revisit on July 8-9, 2013, revealed the corrective actions implemented removed the immediate Jeopardy on June 29, 2013.			445141	B. WING			
SUMMARY STATEMENT OF DEFICIENCIES PREFIX EACH CORRECTION MUST BE PRECEDED BY FILL PREFIX EACH CORRECTION ACTION SHOULD BE CADES FEFERENCED TO THE APPROPRIATE DEFICIENCY Formation Prefix Prefi			REHAB		2910 PEERLESS RD	<u>. 1</u>	<u>U9/2U13</u>
development of policies and procedures to ensure an effective system for supervision of residents at risk for falls. The facility's failure placed four residents (#134, #37, #58, #71) in Immediate Jeopardy (a situation in which the provider's noncompliance has caused, or is likely to cause serious injury, harm, impairment, or death) of eighteen residents reviewed for falls. The systematic failure to ensure any resident at risk for falls was provided effective interventions; failure to ensure alarm devices were in place and/or functional, and failure to identify and implement new interventions when current interventions were not effective was likely to place any resident at risk for falls in immediate The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8-9, 2013, revealed the corrective actions implemented removed the Immediate Jeopardy on June 29, 2013.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FIRE	PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D PP	(X5) COMPLETION DATE
Non-compliance for F-501 continues at an "E" level citation. Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to Accidents and Supervision, Chair and Bed alarms, the System improvement Report and review of evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. The Medical Director reviewed treatment plans and fall interventions for each resident. Inservice and		development of polensure an effective residents at risk for placed four resident Immediate Jeopard provider's noncompto cause serious in death) of eighteen of The systematic falls risk for falls was profailure to ensure at and/or functional, at implement new interventions were or any resident at risk Jeopardy. The facility provided Allegation of Complement of Complement of Jeopardy. The facility provided Allegation of Complement Jeopardy on June 2 Non-compliance for level citation. Validation of the Cre Compliance was accord review, obsert front line staff and at provided evidence of procedures related to Chair and Bed alarm Report and review of Director and Administ approved all policies Medical Director review.	icies and procedures to system for supervision of falls. The facility's failure its (#134, #37, #58, #71) in ly (a situation in which the olilance has caused, or is likely tury, harm, impairment, or residents reviewed for falls. The ensure any resident at ovided effective interventions; arm devices were in place and failure to identify and reventions when current not effective was likely to place for falls in immediate ian acceptable Credible iance on June 29, 2013. A 2013, revealed the corrective dremoved the immediate 9, 2013. F-501 continues at an "E" cdible Allegation of complished through medical vation and interview with dministrative staff. The facility finew policies and o Accidents and Supervision, as, the System improvement fevidence the Medical and procedures. The lewed treatment plans and		2. On 6/25/13, the DON, ADON, Clin Managers and Staff Development Nurreviewed the medical records of all reswith falls for the past 45 days to ensure interventions were in place. There we clarified interventions implemented or residents and put on care plans. PT/O screened each resident at the time of eand evaluations, treatment, or intervent were put into place. The DON review outcomes of these reviews with the Mc Director. On 6/25/13, the DON, ADO Clinical Managers assessed all resident alarms using the new Assessment for A Device. Eleven alarms were removed to on the outcomes of the assessments. Device the evel of functioning, alarms no required and/or no falls within past 90. This was reviewed with the Medical Di All devices were tested for functionality ADON, chair and bed alarm policy C) put into place, assessment of assistive of (E) and alarm check forms (D). On 6/24/13 and 6/25/13, the DON and Staff Development Nurse conducted mandatory in-services for all nursing stroncerning revised fall prevention progwith changed forms, chair and bed alar Any RN, LPN or CNA not attending mandatory in-services will not be allow work until they have attended the in-service within 7 days administered by Staff Development Nurse complete a post-test following the in-service within 7 days administered by Staff Development Nurse complete and services of the services of the services of the in-service within 7 days administered by Staff Development Nurse complete and services of the services of the process of the services of the past the process of the services of the s	idents correct ce new in three T ach fall ation dical N and s with ssistive eased oue to longer days. rector. by were evice for aff ram m. ed to	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/11/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORMAPPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING_ COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013. STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (XE) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAĞ DEFICENCY) Beginning on 6/25/13, the Administrator will monitor Medical Director's attendance at (F 501) Continued From page 34 {F 501} training records including sign-in sheets for all the QAPI committee and that signatures are nursing and non nursing staff related to the new obtained on the reports submitted for review. policies and procedures were provided. On 6/25/13, the DON implemented the Interviews with nursing staff revealed nurses and monitoring tools approved by the Medical certified nursing assistants were following the Director and Administrator necessary to new policy and procedure related to the new fall monitor alarms, restraints, falls interventions, and prevention policy, and alarm policy. Notification of Physician of lab results, changing 02 tubing and humidifiers timely, The facility will remain out of compliance at a medication administered when allergy Scope and Severity level "E"-a pattern of deficient present, accurate MDS assessments and practice that constitutes no actual harm with careplans, dignity of delivery of trays, placing potential for more than minimal harm that is not of clothing protectors, restraints and reporting immediate Jeopardy, until it provides an incidents of unknown origin to State. acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee. 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN (F 505) (F 505) S5≈D OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician of lab results timely for one resident (#134) of lifty-six residents reviewed. The findings included:

FORM CMS-2567(02-99) Praylous Versions Obsolete

Resident #134 was admitted to the facility on June 17, 2009, with diagnoses including Anxiety, Depressive Psychosis, and readmitted August 13, 2013, with diagnoses including right femur

Event ED: 32HM12

Feelity ID: TND601

If continuation sheet Page 35 of 39

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764RINIP. 49//11/2013 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLA	(V2) vites	Plate & and a second	OM	FORM APPROV <u>B NO. 0938-0</u> 3	
#	DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING.		P	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER	445141	B. WING_		1	R	
BRADLEY HEALTH CARE &		5	TREET ADDRESS. CITY, STATE, ZIP CO 2910 PEERLESS RD	DE	07/09/2013	
(X4) ID SLIMMARY ST	ATEMENT OF DEFICIENCES	<u> </u>	CLEVELAND, TN 37312			
TAG REGULATORY OR L	Y AUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)		COMPLETIO DATE	
policies and proced interviews with nurs certified nursing as new policy and proced and prevention policy and prevention policy and prevention policy and prevention policy and prevention policy practice that constitute potential for more the immediate Jeopardy acceptable plan of a corrective measures evaluated by the Quarksessment/Perform Committee. F 505) SS=D OF LAB RESULTS The facility must promphysician of the finding This REQUIREMENT by: Based on medical results facility failed to not the facili	luding sign-in sheets for all rising staff related to the new lures were provided. Sing staff revealed nurses and sistants were following the sedure related to the new fall sy, and alarm policy. In out of compliance at a level "E"-a pattern of deficient ates no actual herm with an minimal harm that is not an minimal harm that is not could be reviewed and ality nearce improvement. APTLY NOTIFY PHYSICIAN inputs notify the attending legs. Is not met as evidenced cord review and interview, tify the physician of lab resident (#134) of fifty-six	{F 505}		usure all of of the tim of to greports ar or each ters. The governing more ofte who were sremoved. evelopment th licensed physician oorts. (Q) pon return DON/Staff will be ort nurse ts checked nely	07/15/13	

Jul. 26. 2013 3:52PM CETARTIMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 6764-RINP. 50-7/11/2013

FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (XQ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BULDING COMPLETED 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LEC EDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION DATE TAG DEFICIENCY) {F 505} Continued From page 35 3. Beginning 7/15/13, the Clinical Managers {F 505} fracture. and Weekend Supervisor will review communications book to MD/NP daily to Medical record review of a Laboratory Result of a ensure compliance of notification of Urine Culture (collection date July 6, 2013) physician/NP. Outcomes will be reported revealed "...Organism...probable proteus..." to DON at the morning meeting per policy (Q). Each charge nurse will continue to Medical record of a Nurse's Note dated July 8, 2012, at 10:05 a.m., reveated "...urine culture note daily on the 24 hour Nursing Report resident change of condition and MD/NP report noted and placed in the NP (nurse orders, including lab reports. practitioner) book for further review." 4. Beginning Aug 2013, the DON will report Medical record review of a Nurse's Note dated monitoring outcomes concerning July 9, 2013, at 4:00 p.m., revealed "...Urine C&S notification of lab results to the QAPI (culture and sensitivity) called to Dr. committee beginning with the scheduled (doctor)...T.O. (telephone order) Ampicillin 8/14/13 QAPI meeting. The Administrator (antibiotic) 500 mg (milligram) QID (four times per will report to the governing body day) x (times) 5 days...placed on MAR concerning these monitoring outcomes on a (medication administration record), faxed to quarterly basis or more often as necessary. pharmacy..." Interview with Unit Manager #3 on June 13, 2013, at 2:30 p.m., in the conference room revealed the culture report was placed in the NP book. Continued interview revealed the NP visited the facility and checked the book Monday through Friday. Further interview revealed the results had been placed in the book on Friday and the NP did 8.5 % not respond. Interview with the Director of Nursing on June 13, 2013, at 2:35 p.m., in the conference room confirmed the facility had failed to notify the Physician timely of a Urine C&S resulting in a delay in freatment. {F 520} 483.75(o)(1) QAA COMMITTÉE-MEMBERS/MEET (F 520) SS=E QUARTERLY/PLANS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLA	<u> </u>		FORM): 07/11/2 #APPRO\ }_0226_b
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(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES		CLEVELAND, TN 37312		
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⁻ 520)	Continued From pag		(F 520)	Resident # 134, # 37, #58, #71, #95, #111 #193, #2, #18 and #13	, #52,	07/15/1
	SSSUIANCE COMMITTED TO THE PROPERTY OF THE PRO	ein e quality assessment and e consisting of the director of	}	1		V//13/1
İ	THE PROPERTY OF THE PROPERTY OF THE	DODICION MANAGEMENT		1) The DON, Administrator, and Medic	ai l	
		other members of the		PARECIOI (EVIEWED AND revised the O to	T-0.	
	facility's staff.	3 37 370		IV/ www prescrited the bian (1) ** * == 11 = 3		
ļ	The quality assessm	ont ond		meeting on 6/25/13 of the QAPI meeting developed a standardized Agenda (J) and		
	CONTRIBUTE LINGUIS 21 1	PORT OF INDIANA LA SAL AND I		PAGING MIMAT III TO ADDITE ON 4	1 2	
	AAAAAA WILLI I BALIMIT T	\ 1000\AB &\TiL	i	Conservice has Demails and Superior		
				Musicily pasts. The following are an	ers of	
	develops and implements appropriate plans of action to correct identified quality deficiencies.			"" You will will the Administration to	I	
- 1		men quality deficiencies.		ADON, Social Services Director, Busines Office Manager, Clinical Managers, Activ		
1	A State or the Secret	ary may not rentile				
			r	The supplier of the supplier o	or,	
	xxept insorar as suc xxmpliance of such o	[r	Michical Dilector		
ļr	equirements of this s	ection.		Attachment: QAPI Plan, Trending Reported quality indicators (J)	ts,	
10	Bood faith attempts b	y the committee to identify	Į,	The DON & Administrator developed nonitoring tools for Palls, Alarms, and	- 1	
	ind correct quality del basis for sanctions.	ficiencies will not be used as	۰,	areplans to ensure safety of all -octations		
٦١	pasis ior sauchons.		μ,	""""", LUC MONITORING tools for C.W. co.		
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[]	his REQUIREMENT	is not met as evidenced	74.	ANTOKETO HERITARIO MILLION CONTROL OF THE STATE OF THE ST	•	
, ~	<i>3</i> •		144	ON to compile an analysis to present to API. A checklist for falls, skin tears, and		
10	DA) Committee & All	e facility Quality Assurance	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	uises was developed for licenced with a	. 1	
fe	icility policy reviews,	ly investigation reviews,	ļu.	se to chighle all information is completed	- 4	
1 131	rdi views. Line tacility f	Alied to occurs the con-well	pa.	use of tail. Lone included fore areas		
(4.0	SOM GLINE COLLULIDADO	Monthing residents a c .	J. 144	" Olic to cusule tracking and complete		
,,	erm use and falls es iprovement.	potential areas for quality	100	vestigation. Fall rosters were developed a d the Charge Nurses in tracking	to	
]""	ihi zaditiri [*		in.	terventions on each resident. The ADON	.	
TI	ne facility's failure to r	eview data and	en:	Sures the section on notification of the	i	
I TQ	muate/molement in	DIAVARIANI piopo ele	lbr.	lysician is always completed on the incide	ent	
ו אסדו	ur resident's (#37, #5	R #74	lfo	rm.	1	

Jul. 26. 2013 3:52PM DEPARTMENT OF HEALTH AND HUMAN SERVICES No. 6764 CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 07/11/2013 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING _ 448141 B. WING NAME OF PROVIDER GR.SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2910 PEERLESS RD CLEVELAND, TN .37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREPIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETION DATE TAG DEFICIENCY) (F 520) Continued From page 37 (F 520) Immediate Jeopardy (a situation in which the The monitoring tools for alarms will be provider's non-compliance with one or more completed by the CNAs daily and will be requirements of participation has caused, or is provided to the DON to compile an analysis likely to cause, serious injury, harm, impairment, to present to QAPL. A copy of the care plan or death to a resident) of eighteen residents is attached to every fall incident for ADON reviewed. The systematic failure to ensure any to review and to ensure that interventions resident at risk for falls was provided effective have been added to the care plan. Interventions, failure to ensure alarm devices Attachment: Checklists (B). incident log, were in place and/or functional, and failure to Alarm checklist (D), Falls intervention roster identify and implement new interventions when (K). current interventions were not effective was likely 2) On 6/25/13 the Administrator, with to place eny resident at risk for falls in Immediate Jeopardy.

The facility provided an acceptable Credible Allegation of Compliance on June 29, 2013. A revisit on July 8-9, 2013, revealed the corrective actions implemented removed the Immediate Jeopardy on June 29, 2013.

Non- compliance for F-520 continues at an "E" level citation.

Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation and interview with front line staff and administrative staff. The facility provided evidence of new policies and procedures related to Accidents and Supervision, Chair and Bed alarms, the System Improvement Report and review of evidence the Medical Director and Administrator had reviewed and approved all policies and procedures. Inservice and training records including sign-in sheets for all nursing end non nursing staff related to the new policies and procedures were provided. Interviews with nursing staff revealed nurses and certified nursing assistants were following the

2) On 6/25/13 the Administrator, with consultation of a Healthcare Consultant, conducted a Department Head meeting to review new QAPI plan, agenda, and monitoring parameters methodology for collecting and analyzing

On 6/25/13 the Administrator developed Quality Improvement Objectives for 2013 to be presented at the July QAPI committee meeting and the July Board meeting. Attachment: 2013 Objectives (L) All staff will report to their respective Department Head to communicate observed problems or concerns.

3) Beginning 6/25/13 the Administrator will conduct timely QAPI Committee meetings monthly, and more often if necessary, to ensure the quality of care is monitored and complies with the standard of care. Beginning 6/25/13, the Administrator will ensure the Monitoring and Trending Reports for falls, alarms, careplans, incident reports, Incident/Accidents, Infections Control, Reportable Events and Environment of care, timely processing of physician orders, hand hygiene, food

Jul. 26. 2013 3:53PM No. 6764 PR DEPARTMENT OF HEALTH AND HUMAN SERVICES 53 07/11/20<u>13</u> CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING . 445141 B. WING NAME OF PROVIDER OR SUPPLIER 07/09/2013 STREET ADDRESS, CITY, STATE, ZIP CODE BRADLEY HEALTH CARE & REHAB 2010 PEERLEGS RD CLEVELAND, TN 37312 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY {F 520} Continued From page 38 (F 520) temperature, medication administration, new policy and procedure related to the new fall allergy noted, protective coverings during and prevention policy and alarm policy. A Quality meals, are all completed. Assurance meeting was held on June 25, 2013 4) Beginning 6/25/13, the Administrator will where the Administrator and Director of Nursing conduct meetings timely, ensure all presented a new standardized agenda to ensure members attend meetings 100% of the time all topics and reports will be reviewed quarterly. with any absences approved prior to The Administrator and Director of Nursing developed monitoring tools for falls, alarms, and meeting and that all monitoring tools are care plans to ensure safety of all residents. The completed in a timely manner for each facility obtained an outside Healthcare Consultant meeting by all respective managers. and along with the Administrator conducted a Department Head meeting to review the new Quality Assurance Plan, agenda and monitoring parameters methodology for collecting and analyzing data. The facility will remain out of compliance at a Preparation and/or execution of this Scope and Severity level "E"-a pattern of deficient plan do not constitute admission or practice that constitutes no actual harm with agreement by the provider that a potential for more than minimal harm that is not deficiency exists. This response is also immediate Jeopardy, until it provides an acceptable plan of correction and the facility's not to be construed as an admission of corrective measures could be reviewed and fault by the facility, its employees, evaluated by the Quality agents or other individuals who draft Assessment/Performance Improvement or may be discussed in this response Committee. and plan of correction. This plan of correction is submitted as the facility's

FORM CMS-2567(02-09) Previous Vetsions Obsolete

Event ID: 32HM12

Facility ID; TND801

creditible allegation of compliànce.

If continuation sheet Page 39 of 39